mental health digest

National Clearinghouse for Mental Health Information, Vol. 3, No. 6, June 1971

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cover story

***Sesame Street* Muppets**

The Muppets now are well-known television stars, for they have become one of the trademarks of the experimental TV show *Sesame Street*. A production of the Children's Television Workshop, *Sesame Street* is designed to teach basic educational concepts to preschoolers and is aimed particularly toward children in inner city settings. The success of this show is but one indication of recent nationwide concern about early development of children; in the National Institute of Mental Health, in fact, child mental health now has top priority. The article beginning on page 29 describes how research in basic educational psychology was implemented in the content and format of *Sesame Street*. (Photo provided by Children's Television Workshop)

mental health digest

The ***Mental Health Digest*** is a monthly publication designed to reflect the whole spectrum of mental health and to present a broad sampling of scientific subject matter and professional points of view. It contains condensations of material selected from the current mental health literature. The condensations are published with the approval of the authors and publishers for use in the *Mental Health Digest* only.

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Use of funds for printing this publication approved by the Director of the Bureau of the Budget, May 20, 1968.

The NIMH and Child Mental Health

Not long after his appointment as Director of the National Institute of Mental Health, Dr. Bertram S. Brown announced that mental health programs for children would be the NIMH's "Number One priority." Shortly thereafter, Dr. Brown appointed a 16-man Ad Hoc Committee on Child Mental Health to review the Institute's programs for children and youth and to suggest new and expanded efforts to meet the mental health needs of children. The Committee, NIMH staff representing diverse professional disciplines, was charged with the task of coming up with recommendations that could be implemented within the next 12 to 18 months. The Committee's report is now available.

The report begins by quoting the Joint Commission on Mental Health of Children. "our claim to be a child-centered society is a myth." Statistics give credence to this observation. For example, in 1969, more than 900,000 children were brought before juvenile courts; in 1968, 437,000 children were seen in outpatient psychiatric clinics, 33,000 were in mental hospitals, 26,000 were in residential treatment centers, 13,000 in day/night services, and 52,000 in community mental health centers. The need to do more for our children could not be clearer. And the NIMH must assume a leadership role in stimulating and creating mental health resources for those who need help.

The Committee based its recommendations on two assumptions: The child should be viewed within a developmental framework—a continually evolving, developing, growing individual whose needs and strengths change with age. Although all stages of development are important, the Committee singled out two: early childhood and adolescence. The child should be viewed within the context of his environment—his total "social ecology."

The need for collaboration between all human service agencies that serve children is essential. The collaboration should begin at the Federal level, with more active cooperation between the NIMH and other Federal agencies. Such cooperative efforts will be a powerful stimulus toward collaboration between other groups—State, local, and private. Collaboration between certain kinds of services is important—the educational system, the health care system, social and welfare agencies, the justice system, and day care agencies. Collaboration is especially required in preventive programs, which in many cases can be achieved only through cooperation and combining of resources. One way to encourage collaboration is through child and family advocacy programs.

Prevention

The Committee's proposals for expanding the Institute's preventive programs fall into seven categories: family care, day care, the school system, measures relating to young people, the health system, the legal system, and the community mental health system.

The Committee recommended that the NIMH support demonstration projects to help parents and future parents obtain a better understanding of the psychological aspects of normal and abnormal child development. It should also develop training, consultation, and counseling programs to strengthen and support family care; develop training methods that will shift emphasis from child-centered to family-centered approaches to prevention and treatment; and collaborate

with other agencies in developing family planning material.

The Institute should evaluate existing models of mental health input into day care programs and develop improvements in them; promote mental health input into day care programs through collaboration with the Offices of Education, Economic Opportunity, and Child Development; insure that Federal and State standards include mental health considerations; develop mental health materials for training day care workers and those responsible for licensing centers; and collaborate with the Department of Labor on training projects.

Collaboration with Office of Education teacher-training programs to introduce information on child development and mental health principles into the classroom is recommended, as well as collaboration with State and local boards of education in sponsoring conferences on child development and school-related mental health information for teachers and administrators. The Committee also recommended that the NIMH fund jointly with the Office of Education certain demonstration projects, such as projects designed to prevent learning disabilities; use its research grant mechanism to produce information on how schools can work toward prevention of learning disorders, alienation, racism, and violence; and identify successful models of college mental health programs and disseminate them to the field.

The Institute is urged to create opportunities for young people to participate in Institute activities by having persons under age 30 serve on Review Committees; have more summer jobs for young people; convene ad hoc youth advisory councils for programs directed at young people; and encourage research projects focusing on youth to use youthful employees. In addition, the Committee recommended that the NIMH expand its research programs on factors contributing to adolescent turmoil, support expanded public information and education programs to present youth with facts about social problems, such as drug abuse, suicide, etc.; and consider a system of behavioral science awards for high school and college youth.

Of the many ways that the NIMH can work with the health system, probably the most important are family planning and pre- and postnatal care, with effective dissemination of information being particularly needed. Another important area is related to hospitalization for physical illness and the necessity to teach hospital personnel to provide emotional support for hospitalized children.

The recommendations for preventing mental illness through the legal system include working collaboratively with the Department of Justice to insure that emotionally disturbed individuals are handled properly, to provide mental health services in institutions, and to prevent recividism in first offenders. Joint projects with the LEAA National Institute of Law Enforcement and Criminal Justice and increased dissemination of information on prevention of delinquency and treatment of delinquents are suggested.

Through consultation with personnel in the community mental health centers and through priority rankings on grants, the NIMH should encourage the centers to work in all areas of preventive child mental health. Working with the centers is viewed as a unique and powerful means of implementing the program.

Services

The recommendations emphasize

the community mental health centers, with suggestions that the centers be encouraged and stimulated in all possible ways to expand their services for children. Also recommended is improvement of services for institutionalized children—a relatively small but growing population—through priorities in the Hospital Improvement Programs. Demonstration projects are deemed to be of particular importance, especially to provide information on the needs of different kinds of communities and on the methods that work best in each kind. The Institute should undertake a continuing program to assess and develop the state-of-the-art of community-based child mental health services. All NIMH service program resources should be drawn into this effort.

Manpower and Training

The scarcity of personnel trained to work in child mental health is a major barrier. If NIMH is to implement its high priority for child mental health, it must modify its support of training activities. Specifically, the Institute should increase the capacity of training institutions to provide training which focuses on children's needs. This will often require a considerable change in existing training programs. And it will include training not only traditional mental health personnel, but those in other fields, such as nonpsychiatric physicians, social and welfare workers, criminal justice personnel, etc. There should be expanded training programs for new types of child-related mental health specialists, such as "child-care workers," "child development specialists," and "child development counselors," and a sizable part of the NIMH's resources for "new career" training should go into child mental health.

As in the area of prevention and treatment, the Committee recommended greatly increased collaborative efforts with other agencies and programs. Cooperation with the Office of Education in training school personnel—a program needing particular attention—is emphasized. Complementing the other recommendations concerning day care centers, the Committee recommended a wide range of training programs for persons working in such centers, including short-term courses for State personnel involved in licensing and inspection, workshops and conferences for personnel providing consultation to day care centers, and the development of do-it-yourself packages for education of day care personnel for use by State and local agencies, extension divisions, and community colleges. Training for the new advocacy approach is also necessary.

Research

Research, the Committee maintained, is the soundest way to arrive at an understanding of human behavior and development. The Committee focused on three questions: What are the research needs? How best can research serve society? How best can relevant research be fostered? It then pointed out that child mental health is not a categorical research domain, but rather a broad grouping of studies devoted to the psychological development of children and the factors influencing their development and behavior.

Highly noteworthy is the fact that only in the past 25 years, and particularly the past 15, has there been a strong research movement into child development, personality, and behavior. Only in this period have theories, experimentation, intervention procedures, and interdisciplinary work grown into a recognizable entity that can be identified as child mental

health. In other words, the basic knowledge relating to child development and behavior is seriously incomplete; most of its findings and certainly the interpretations and generalizations are subject to change.

A further historical perspective is deemed essential: Many advances in understanding human processes and behavior, and many intervention and treatment approaches to behavioral and emotional disorders in children, grew out of research that was not in any way conceptualized or directed toward children or mental health problems.

Before presenting recommendations for NIMH research policies, the Committee reviewed briefly the current situation. In extramural research projects, there are 178 grants judged to be primarily related to child mental health, 62 grants related secondarily to child mental health, and 36 grants of peripheral relevance. Financial support in fiscal year 1970 for grants categorized as "primarily related to child mental health" was $10,239,180 or 13.17 percent of the total NIMH extramural research support. As of June 1970 the intramural program had 46 projects of relevance to child mental health, and one-third of its professional man-years devoted to this area.

Of prime significance is the fact that the Committee recommended that the Institute commit itself to basic research relating to child mental health and to the encouragement of the highest quality of basic, cumulative research. It also asserted that more effective research could be done and the research now being done could be more effectively utilized. The NIMH should facilitate improvements in a variety of ways, including encouragement of syntheses of existing knowledge, providing for planning and funding of longitudinal research, placing greater emphasis on comparative studies, and fostering communication and collaboration among investigators.

The Committee also identified several specific areas that deserve research priority, at the same time stressing that a wide variety of research directions should be maintained.

Special Issues

The Report also covers special issues of minority group mental health, development and utilization of knowledge, program collaboration, and setting standards.

Implementation of the Committee's Recommendations

Throughout the Report specific suggestions are made for implementing the recommendations. The decision to make the mental health of children the Institute's Number One priority will have a profound impact and will greatly change the activities of many staff members.

Some of the ideas and recommendations can be implemented with existing resources and manpower. For example, the Committee recommended earmarking presently available funds for certain research and training activities. "In the long run, however, the Committee believes that greatly increased funding and manpower and new, imaginative programs will be required if a lasting improvement in the mental health of American children is to be effected."

Copies of the 65-page Ad Hoc Committee on Child Mental Health *Report to the Director,* National Institute of Mental Health, February 1971, P.H.S. No. 2184, are available for 40¢ each from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

The Capacity to Love: A Possible Reformulation

Irene M. Josselyn

Previously I raised the question of the possibility of an inherent drive—the Alloplastic Drive—referring to the capacity to love others, a capacity which I postulated was based on an inherent need that evolves into a need to love.

Development of the capacity for object relationships, as conceptualized in dynamic psychiatry, suggests that the infant's biological need for the mother evolves into the psychological need to be loved, and thus becomes the foundation of security and trust. The assumption is that during this neonatal period the infant is the passive recipient of biological nutrition and stimulation. As the infant becomes aware of the self and the not-self he recognizes the source of his early gratification and frustrations. He then identifies with the giving and depriving maternal figure; from these two conceptual experiences he develops the capacity to love and to hate. Thus the beginning of love for another is based both on love for part of the self (the newly acquired introjected object), and on identification with the individual who gave love to him.

This formulation is based on a concept of neonatal life characterized by biological passivity. Yet the infant is not passive; within his sphere of competence he actively seeks gratification. This is nowhere more sharply indicated than in a normal newborn. When hungry or seeking satisfaction for his need to suck, he roots. If his cheek is touched, he turns his head toward the source of stimulation. When his lips are touched, he opens his mouth and sucks. Until his hunger and/or sucking needs are met he is active; it is his mother or the bottle that is passive—the passive givers. The neonate turns outward for need gratification; only when his active seeking is unrewarded does he turn inward for satisfaction, utilizing his own stored fat.

This turning outward is a biological phenomenon, not a psychological one. The need for food, for sensory stimulation, and for the other multiple components of the infant-mother relationship appear to be essential for development. They are basic to the establishment of the functional division of the organism into the psyche and soma and this differentiation leads to the psychological experience of a sense of security and trust. The components of the infant's psychological dependency and need for love thus have a biological anlage—the anlage of one psychological root of the personality, the seeking of love from others. The biological response of turning outward for need-satisfaction becomes manifested, with the establishment of the psychological component of the human gestalt, by a continuing pattern of turning outward, this becoming a capacity to love as well as to accept love.

As the self-non-self differentiation occurs, according to current theory, the memory traces laid down during the neonatal period result in a continuing positive emotional investment in the original sources of pleasure. But is it not possible that the inherent pattern of turning outward has brought about a positive affective response to the gratifying object that

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was found during early exploration, a response that becomes the psychological experience of loving?

There is a suggested confirmation for the hypothesized Alloplastic drive in the history of some severely autistic children. In reviewing the development of such a group the mother typically reports that the child was a good baby, undemanding, and contented when alone; it gradually became apparent that he was not responding to others. Is it not possible that the autistic child whose infancy seemed to provide a gratifying environment had, for some reason still obscure, weak or absent Alloplastic drive so that energy was not directed toward the outward goal, but to the more limited area we recognize as typical of the autistic child?

If there is an Alloplastic drive, its failure to find expression may not be the result of an inherent lack. It may come about as a consequence of atrophy from disuse, or of repression because it led to too much pain when expressed in early childhood. During analysis certain adults describe an uncomfortable emotional tone. They say they feel lonely, not lonesome. Stripped of personal implications, loneliness is a response to an internal need that they cannot satisfy; lonesomeness is something external for which they can anticipate relief when they are with others.

The complaint of loneliness is not rare during analysis when the defense against the longed-for infantile dependency weakens sufficiently for the longings to become manifest in the transference. Insight into this transference meaning leads to ego mastery in the reality world. Some patients still complain they are lonely. A superficially similar symptom is manifested by the immature, narcissistic individual who seeks to be loved by others but has little capacity to love those who do not comply with his needs. In the latter cases for a long, sometimes interminable, period, insight does not bring about a mobilization of the ego-adaptive mechanisms; only replenishment in the transference is effective. This seems transiently to provide the achievement of the unattainable goal of finding the Utopia of infancy, and maturation may ensue.

In my experience a patient offered a clear example of another explanation for the feeling of loneliness. He sought analysis because he wished to enrich his competence in his work. He was skilled and brilliant in personnel management, and his relationship to others was interpreted as very personal by those whom he tried to help. Married, with two children, his relationship with his family seemed positive. Until the age of eight his life had been that of a child in a typical middle-class family. The one atypical aspect was his brilliance—an I.Q. in the upper 180's. Understandably, he was not as dependent as would be expected for his chronological age. His mother died when he was eight; he did not grieve. Reality had taken his mother from him; reality went on. He continued his outstanding achievement, was a sought-after member of his peer group, and was respected by his teachers. The only subtle change was that he offered the protective aura for his father and older sister that his mother had provided. As he reached adulthood and professional achievement he was neither pseudo-humble nor domineeringly aggressive. He believed in himself and seemed to feel no need to support artificially that belief. In analysis he explored himself with only the mobilization of those defense patterns that enabled him to respond to insight with further exploration. The most painful part was

when, in the transference, he mourned for his mother. His longing for a dependency relationship with a mother figure became clear. Once he had experienced mourning he became aware that his relationships with others offered him, on an adult level, what his mother had given to him. While this made him free to accept from others, he still felt lonely. He then focused on his concern that he did not know what it meant to love.

In spite of his awareness of the nature of his relationships with others his analysis did not free him of his inability to experience the affect of loving. Even five years after termination of therapy, he expressed in a letter that as hard as he had worked in his analysis and post-analytically, he was still lonely and did not know what it meant to love.

As I reviewed cases in which loneliness persisted, all but two patients had a common characteristic: They were brilliant people who mastered self-care earlier than would the average child. Their parents did not exploit their child's intellect, but were intimidated by it. Mothers were awed by their child's ability and appeared unable to function in an infant-mother role, so it was easier for the child to turn to himself for need-gratification than to turn outward to clumsy adults. The Alloplastic drive failed to mature because it was used so minimally.

Failure of maturation of the Alloplastic drive in two other cases had a different etiology. Both mothers suffered from a postpartum depression followed by recurrent depression with irrational, fearful outbreaks of anger. Substitute mothers were frequently changed, and relatives provided unpredictable brief contacts. Both children appeared to make a good adjustment and were described as remarkably self-reliant children. Fear aroused by the mother's psychosis was re-experienced in the transference, however, and in both cases the transference neurosis provided a corrective experience that facilitated expression of the Alloplastic drive through other interpersonal relationships.

In these cases I became convinced that the problem was either an inability, or a fear, of loving even though they could recognize their need and longing to be loved. But a formulation based upon a limited number of psychoanalytic cases is subject to criticism unless it can be translated into an understanding of more general manifestations. There are many facets of our society that support the conclusion that many people have a great need to be loved but a limited capacity to love others. The group that appears to recognize, to suffer from, to seek an answer to, and to verbalize the difficulty most clearly is a subgroup of the adolescent culture. They describe a wish for mutuality which they seem unable to find except under drugs, in non-promiscuous sexual relations and/or in a common social cause. This attitude is not unique; adolescents have always sought intimacy with others. The uniqueness at present is the frantic way in which they seek a mutual relationship and often find it void of any real gratification. The love object they seek has no greater capacity to love than they themselves possess.

There is an interesting phenomenon among the adolescent group that challenges explanation. Their dancing is not close; each dances independently of the partner. Yet certain members of this group describe meaningful experience during intercourse. In describing the latter they emphasize not sexual satisfaction, but the ecstasy of feeling close, something they never felt before. I asked a patient why dancing wasn't

used to express the same closeness as intercourse. Her answer was that dancing and intercourse were different; when you danced you were in an ocean world, carried away by the waves of music—no one but yourself really mattered. Intercourse was an interpersonal experience with someone you loved; it gave you a period of feeling close; she wished it didn't seem so ephemeral and brief.

One aspect of the adolescent subculture that seems to be unique is the "love-in." This phenomenon does not appear to be dominated by a need for promiscuous sexual discharge, but by a need to be loved and to love. The liaisons are sought with intensity; the love and loving desired are not for one person, but for all who are seen as capable of loving and being loved.

Another aspect of the behavior of certain adolescents that may indicate frustrated longing is their violence, acted out or verbalized. There is no single explanation, but in some instances perhaps it is related to anger arising from the feeling that something they want to love does not seem to them lovable.

It was interesting to observe the rapid evolution in thinking of a patient who was a leader in the planning for a riot aimed at destruction of buildings. He and a woman member of the group became aware that they loved each other and decided to marry after they graduated. In therapy he then talked of how the University should change, how the Government could be improved. He and his fiancee remained leaders of the rebel group, and persuaded their followers that destroying the University would deprive them of education and that members of the administration were so frightened by the threat of destruction they would retaliate by repression. They had indicated that a sound approach was to discuss problems with the administration, since they and the administration had a common goal.

As he discussed the change in his own view, he related it to the time when he, for the first time, was aware of loving someone. At the same time his vocational goal also changed, whereas he previously had planned to devote his life to the "political activity" revolution he decided to specialize in education or social work, which he felt would be more constructive. It appeared that having found that he could love, his tolerance for frustration had increased. He could accept ways to achieve a goal that were constructive, whereas previously he had sought his ends through planned discharge of global rage.

The popular concept is that parents in this affluent society give material things to compensate for and disguise their inability to love. Two causes would seem possible. One group appears capable of loving the child, giving of themselves as well as material benefits. This affective response provides the child the aura for an essential sense of security. The second group knows they should meet their child's emotional needs but they also insist that they themselves have needs and the child can't expect everything. These parents were reared during the period in which the popular attitude was that the child should be loved with no implication that the child should also experience loving another; his psychological growth would make that response inevitable.

Why has this happened? If my hypothesis is correct, it follows that an inherent capacity to turn outward had atrophied, and realization of the potential capacity to love did not adequately develop. Parents can unintentionally bring about early atrophy of the capacity to love. With the motiva-

tion of giving security to the child early they deprive the child of the experience of valuing an object and mourning its loss. For example, when the child cries over a broken toy, many parents say, "Don't cry, we will get another one," thus depriving the child of an opportunity to discover he loved the object and to mourn its loss.

I had an experience with a parent-child relationship that contrasted with one I observed in the analysis of an adult. The adult, Tom, indicated that during his pre-adolescent years he had a dog that was killed by a car. His mourning was intense; in fact the dog had significance during many aspects of his analysis. He recalled that his parents had obtained another dog. His parents pointed out that this dog would not substitute for the lost dog, but it would be a source of pleasure. He resented the new dog; but finally it took on a personality and role, and Tom formed a real attachment for the dog, not as a substitute but because of the dog's unique role.

In contrast to Tom's reaction was that of Jane's response to a similar event. She too expressed grief when her dog was killed; her family obtained another. Her parents told her that a dog was only a dog, and this puppy would take the place of the lost one. The parents wondered why she was not concerned when her second dog ran in front of cars. Her explanation was, "You can always get a new dog." Maybe she will feel that one can always get a new husband!

Jane's attitude may have been extreme, but in less intense form it is recognized by parents. They complain that children are careless with their possessions; the object has no intrinsic, specific value. Child specialists can argue that one goal of child rearing is to stimulate a love for people, not for things. But things can have symbolic meaning or can be loved because of their function irrespective of human relationships. Pathology occurs when things *replace* human relationship, but that is the consequence of faulty experiences with human beings. The *thing* then becomes a substitute rather than something valued for itself. It is interesting that as children have shown little love for toys, the complaint has grown that individuals prize most highly the acquisition and exhibitionistic possession of things!

If this hypothesis is correct it has significance in our work with adolescents. It is important, with adolescents as well as with patients of any age group, that we empathize with them. I would suggest that we differentiate between empathizing and identifying. Identification implies being the same as another. Empathy does not result in the fusion of one's own identity with another's, but rather in an *understanding* of the feelings the other person is experiencing while maintaining a separation that allows for independent judgment.

If we identify with adolescents we believe they are right, and those they oppose are wrong. If we empathize we can understand why they feel frustrated or seek goals that will relieve their dissatisfaction, but we recognize that their solution may be naively formulated, without a grasp of the broader implications and the impossibility of a sounder solution. Perhaps too many of us identify with the adolescent rather than empathizing with him.

It is important to empathize with the adolescent who seeks relief by utilizing drugs that are known to be dangerous. If we identify with him we find it difficult to question his solution.

The adolescent is seeking an experience of mutuality, a reciprocal relationship. Because too many adults turn

a deaf ear to his pleas for help in his cultural dilemma, are recriminatory, or deny the underlying cry for assistance, the adolescent turns to those who identify with him and seem to promise mutuality. While the former group attempts to repress him, the latter group gives him verbal support for the same immature mode of expression. The young person has few to trust. To whom can the young person turn who will empathize with him and because of mutual caring, help him find an answer that will lead to a better world rather than a state in which, the bathwater having been thrown out, the baby is missing?

Don faced his failure of adults who identified with his cause but did not respect his needs. He was an excellent student, but resentful of "The Establishment" as represented by his University. He was an "activist." With encouragement of adults who sympathized with the activists, a section of the library was destroyed. In spite of Don's affiliation with those who saw destruction as the answer, the destruction of the library was to him a new deprivation. His comment was: "How, if these people [referring to an older group, including faculty] care about me and those like me, could they destroy what was important to me?" The answer is that they didn't care; they cared only for themselves and valued only an expression of their own hostility. Don's response was that he could not love those who did not love him enough to protect the library, nor could he love those who offered only restraint rather than offering true mutuality for working toward a solution. His decision rested upon the hypothesis that no one loved him enough to help, and no one was dependable enough to be the recipient of his love.

The adolescent whose Alloplastic Drive has atrophied may be able to remobilize a capacity to love others if he finds that those working with him are capable of caring about others and offer an understanding broader in scope than just expressed identification. Our culture is threatened with the holocaust of a psychological atomic bomb if there is not a resurgence of the capacity to care for others beyond those with whom we only identify, a capacity to see beyond the self and those like us, and a capacity to seek wise solutions, not solely through identification but through searching for an "Alloplastic" rather than an "Autoplastic" solution to multifaceted issues. How many adults are failing the young person because they have developed in an environment that did not give due nourishment to the wish and need of an individual not only to be loved, but also to love?

Heritability of Personality in Children

David R. Owen and Jacob O. Sines

Although many studies have been concerned with heritability of intelligence test scores, literature on the heritability of personality variables is much less extensive. The purpose of this research was to estimate the heritable variance in scores of several personality-relevant test scales for children between the ages of 6 and 14 years.

By means of a search of schools in Missouri, a population of 128 pairs of same-sexed twins was identified. All were contacted by letter, and the parents of 42 pairs returned a form indicating their willingness to participate. Zygosity of the participants was diagnosed from blood typing with 23 antisera resulting in 10 male monozygotic (*MZ*), 8 female *MZ*, 11 male dizygotic (*DZ*), and 13 female *DZ* pairs. Since an equal number of *MZ* and *DZ* would have been expected, perhaps the more obviously *DZ* pairs were less motivated to participate by the prospect of a free zygosity diagnosis. If so, this study would be biased conservatively in ascribing importance to genetic variance.

Two requirements must be met for the twin method to allow generalizations beyond the sample studied. Differences between *MZ* and *DZ* twins should not be attributable to differences on nongenetic variables, and the twin sample should be representative of the whole population of children. These assumptions were tested. The congruence of the male, female, and combined *MZ* with their respective *DZ* samples was evaluated against several criteria: equivalence of *MZ* and *DZ* age distributions; equivalence of *MZ* and *DZ* school grade placement distributions; similarity of *MZ* and *DZ* Socioeconomic Status (SES); equivalence of birth order and maternal age at the twins' birth. *SES* scores were computed on the basis of education and vocation of the head of the household.

MZ and *DZ* score distributions were equivalent to one another for each scale used. Also the representativeness of these twins to the population of children was evaluated by comparing the standardization distributions to the *MZ* and *DZ* samples for each scale used. These equivalences were tested with *t* tests on the means and maximum/minimum *F* tests on the variances. All 207 *t* tests were insignificant. Of the 138 *F* tests, 25 were significant. There was some tendency for Verbal IQ, Performance IQ, and Full Scale IQ variances in the female and combined samples to exceed the normative population variances.

After a blood sample was obtained, the Wechsler Intelligence Scale for Children (*WISC*) and the Missouri Children's Picture Series (*MCPS*) were administered to each child. In no case did an examiner test both members of a pair.

The *MCPS* consists of 238 line drawings, each on a 3 x 5 card; each portrays the figure of a child engaged in some activity or situation. The subject sorts the pictures into two groups, those that look like fun and those that do not look like fun. Criterion-keyed scales for Conformity, Masculinity-femininity, and Maturity have been developed and cross validated on a sample of boys and girls ranging in age from 5 through 16. The next five

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scales, Aggressivity, Inhibition-withdrawal, Activity level, Sleep disturbance, and Somatization, have been developed on the basis of differences of responses of appropriate criterion boys and an age proportional sample of unselected school boys. An additional scale is based on the number of pictures sorted into the not-fun category.

Separate analyses were conducted for males, females, and the combined sample, with age-related variance partialed out by converting raw scores to standard scores on the *WISC* and to *T* scores on the *MCPS*. A heritability estimator requires that between-pair variances (*BCMS*) of the *MZ* and *DZ* sets be equivalent. This was established statistically by dividing the larger of the two by the smaller. Of the 69 *F* tests, 7 pairs of the *BCMS* were unequal at the .10 level. Intraclass correlations (R) were obtained from both *MZ* and *DZ* sets on all scales. A significantly positive R_{MZ} was required before conducting further analyses on a scale.

The significance of genetic influences for surviving scales was tested by $F = \frac{WMS_{DZ}}{WMS_{MZ}}$. For scales with significant genetic variance, estimates of the within-family heritabilities were computed from the formula, $H = \frac{WMS_{DZ}\text{-}WMS_{MZ}}{WMS_{DZ}}$

This statistic is not a true estimator of h^2, the ratio of additive genetic variance to phenotype variance, but it may be used to rank a set of variables in order of the contribution of hereditary components.

Results

Within the male sample, six scales demonstrated statistically reliable heritable variance. Within the female sample, five scales had statistically demonstrable heritable variance. A greater proportion of the scales in the female sample have significant R_{MZ}s than in the male sample, highlighting the need to analyze males and females separately. In the combined sample, all measures had significant R_{MZ}s with nine demonstrating reliable heritable variance.

In this study, IQ served as a marker variable to provide additional evidence of the representativeness of these twins. The consistent finding of a Full Scale IQ heritability of .77 in the total sample replicates the findings of other investigators, and is close to the median .72 of a large number of other studies. The existence of genetic influences on measured intelligence is fairly well established. That this sample was in its major aspects congruent with earlier findings is reassuring as it comes time to examine the findings with the *MCPS*.

In the combined data, *MCPS* Scale 5 (Inhibition-withdrawal) met all the requirements for a significant genetic contribution to score variance; the estimated H was .58. Scale 5 falls just short of significance for males alone, with H at .54. Scale 5 was constructed from items that differentiated unselected boys from boys whose mothers described them on a checklist as not participating in group activities, hanging back, fearful, shy, timid, seclusive, preferring to be by themselves, quiet, not standing up for themselves, staying largely in room or house, apathetic or underactive, having few close friendships, crying easily, sensitive, preferring to be with younger children, and speaking in a weak voice. The descriptive label "inhibition" seems appropriate.

The heritability of some trait of other-person orientation, sociability, inhibition, or introversion has been demonstrated in a number of other studies with a variety of instruments.

Scale 3 (Maturity) in the male analysis indicated a significant *H* of .66. Scale 3 is composed of a set of items selected for their age relationship among boys and girls. Thus age served as the operational definition of "maturity." The R_{MZ}s were positive and significant in all analyses. However, only in males examination reveals a distinct, though not significant, difference in $BCMS_{MZ}$ and $BCMS_{DZ}$ for boys. The interpretation of heritability becomes strained when the score distributions of *MZ* and *DZ* twins differ. The assumption of similar environments is brought to task when these *BCMS* values are unequal.

MCPS Scale 10 (Number not fun) in the combined sample also demonstrated a significant heritability of .53, even though the *H* of .72 for males alone was not significant, and for females the *R*'s were not in the required direction. The findings of an overall heritability for Scale 10 coupled with the presence of heritability for Scale 3 in the males raises the question that one of these scales, or their interaction, taps some developmental maturity level which may be gene influenced.

Scale 6 (Activity level) presents an interesting situation for boys. The difference between R_{MZ} and R_{DZ} is significant, but R_{MZ} is not significantly positive. Negative correlations within the *DZ* sets occur throughout the data for Scale 6, which might lead one to speculate about a dominant-submissive relationship within *DZ* pairs which is overcome by common heredity within *MZ* pairs. Thus, although *MZ* pairs fail to correlate positively, they consistently do not correlate negatively as do their *DZ* controls. The estimated heritabilities were .54 overall, .57 for males, and .49 for females. Scale 6 was constructed to differentiate unselected boys from boys whose mothers described them as overactive, becoming wound-up, overtalkative, becoming more active or more talkative in groups, distractable, having a short attention span, talking rapidly, singing or humming continually, having many accidents, and being awkward. Further research with *MCPS* Scale 6 may demonstrate reliable heritability for the trait or behavior dimension of activity level.

Unequal *BCMS* values make the proposed analysis impossible for Scale 4 (Aggressivity). However, if one converts the *R*'s to unit normal variates and tests the difference, R_{MZ} is significantly greater than R_{DZ}. Scale 4 was constructed to separate unselected boys from boys whose mothers described them as hurting, annoying and teasing other children, taking advantage of others, expressing a desire for revenge, blaming others for their own actions, screaming more than others, having temper tantrums, picking on weaker children, destroying property, lying, being selfish, fighting, threatening to kill someone, playing with matches, stealing, and hurting animals. There has been little research with humans on the heritability of aggressivity, but evidence with animals indicates breeding for aggressive behavior is possible.

The results of this study provide evidence that genetic influences over several personality-relevant dimensions, previously noted in adults, can be detected in much younger children by means of an objective measuring device.

The Development of Children's Preference for Their Own Country: A Cross National Study

H. Tajfel, G. Jahoda, C. Nemeth, J. D. Campbell, and N. Johnson

There is general consensus in the literature that children come to "prefer" their own country to others well before they are able to form, understand, and use the relevant concept of countries or nations. This discrepancy between the development of concepts and evaluations exists not only with regard to countries and nations but also in the case of attitudes pertaining to racial, ethnic, religious, and social groups. Several studies have shown that evaluations precede understanding whether the relevant groups are or are not in direct contact (e.g., racial, ethnic, or religious groups living side by side as contrasted with nations), and whether physical or behavioral cues do or do not exist to facilitate discrimination (e.g., racial groups in contact as contrasted with, for example, religious groups in contact).

Studies have shown that at the ages of 6–7 the concept of nation is still rudimentary and confused for most children. Our purpose was to show that, at the same age, there is already a crystallized preference in children for their own country, and to trace the course of development of this preference until the age of 12. We wished to use no more than the "word" or the national label to elicit children's preferences, to do this in a manner which would not involve young children in complex verbalizations, and to avoid the weight on the children's responses of heavy normative pressures—such as exist when, for example, preferences for national flags are requested. We also attemped to establish as much free choice of responses as possible by using ambiguous stimuli and by introducing a considerable time lag between the presentation of the national label and the relevant evaluations. At the same time we attempted to develop a method which would have the advantage of unambiguous comparability both cross-nationally and across age groups.

Subjects for the study were drawn from primary schools in Oxford (England), Leiden (Holland), Vienna (Austria), Glasgow (Scotland), Louvain (Belgium), and Naples (Italy). In each sample, half of the children were male, half female; they ranged from 6 to 12 years of age.

In each country the same experimental method was used. Twenty-three standard photographs of young men were used in all the countries. The child was presented with 20 photographs and asked to put each photograph in one of four boxes respectively labeled "I like him very much", "I like him a little", "I dislike him a little", and "I dislike him very much." In a second session, the child was told that some of the photographs were of people of his own nationality and that some were not. He was then asked to decide whether or not each photograph was of his own nationality. In the Louvain study, half the subjects sorted the photographs on the basis of Belgian-Not Belgian, while the other half sorted them on the basis of Flemish-Not Flemish. At the start of each session, the child was given three pilot photographs to ascertain his understanding of the instructions.

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In all samples the proportions of photographs assigned by the children to the categories of "own" nationals and of foreigners were close to 50 percent.

The main findings of the study are:

1. In all locations except Glasgow, there is a significant tendency to assign better liked photographs to one's own national category.

2. The strength of this tendency decreases with age with the exception of Louvain, where there is a marked increase of the correlations with age. For children tested in England, Belgium, and Austria, the tendency is still strong and significant in the older age-range tested.

3. There is a marked agreement between all the locations in the selection of photographs that are liked.

4. There is also a marked agreement between all the locations, with the exception of Naples, in the assignments to own national category.

5. In all cases of positive relationships between liking and nationality assignment except Naples, the cross-national agreement in nationality assignment increases with age. No such general age tendency appears in the case of cross-national agreement on liking. The Naples data provide a marked exception to the assignment pattern: comparisons of other locations with Naples show a tendency for a decrease with age of agreement in nationality assignments.

6. In all locations, there is high agreement on liking between the younger and older children. This also applies to nationality assignments with the exception of the data from Naples.

The general findings are as follows: Through an association of national verbal labels with preference sorting of photographs one can elicit from young children a clear index of preference for their own national group. This relationship weakens with age. It would be naive to assume this decrease is due to a decrease in "nationalism." It seems more likely that for the younger children both sets of judgments tend to be based more directly on the same affective criterion and that this is the way in which they solve the problem presented to them by the highly ambiguous task of nationality assignments. It is possible that in the older age group separate cues begin to function for liking and for nationality assignments, that an effort is made by the children to approach the two kinds of judgments with different criteria. There are indications that a physical national stereotype develops in children with age. It is possible that the subtle cues for this stereotype do not fully overlap with the cues for liking of individual photographs, and that there is an area of random variation in the relationship between the two.

In addition, previous studies have shown that, with regard to the concept of nationality, a great intellectual growth occurs within the span of a few years. A relatively mature concept of nation could be strongly related to positive attitudes toward one's own country without having to express itself through rudimentary preferences for photographs which appear—rather dubiously—to be of one's compatriots. It is likely that in younger children a more primitive kind of national preference which still remains at a preconceptual stage makes use of any simple affective symbols that it can find.

The agreement in national assignments between the first four locations in which positive results were obtained led to the Naples study. Cross-national comparisons of the Naples data with the others strengthened the case for the existence of a physical stereotype of own nation which develops with

age. If this interpretation were to be supported by further research, it would lead to some interesting questions. Is this an "ideal" stereotype based on mass communication media such as comics, cinema, television, advertisements, etc., in which certain phyical "types" are used, or is it based more directly on a distillation of cues from the "real" social environment? The second alternative does not appear very plausible. On the other hand, there also exists the possibility that a negative stereotype develops because of frequent presentation of "undesirable aliens" as having certain physical characteristics in comics, cartoons, films, etc. The difference in the physical stereotypes between Naples and the other locations could be explained on this basis only if it could be shown that the heroes and villains to whom the Neapolitan children are exposed in various forms of visual fiction look different from their equivalents in Oxford, Louvain, Leiden or Vienna. Alternatively, it is of course possible that the general physiognomic ecology of Naples is sufficiently different from that of the other European locations in which we worked to have produced the differences that were found.

The two main findings—of a significant relationship between preference and nationality assignments in the younger childen and of its decrease with age—have two exceptions: in Glasgow where this relationship hardly exists; and in Louvain, where it shows a considerable *increase* with age. The common feature of Glasgow and Louvain is that, as distinct from the other four locations, nationality assignments present there a task which is altogether more complex. The effects of this complexity are very different in Glasgow and in Louvain. The early confusion in Louvain (shown also by a weak correlation in the data from younger children between assignments as Flemish and as Belgian, and relatively weak correlations in liking between the younger and the older children in both the Belgian and the Flemish versions of the task) gives way in the older age groups to firm preferences for their own national group—whether expressed as Belgian or as Flemish. One can speculate that the lack of a simple and unique national label for the Flemish children combined with the high salience in the country of the binational issue and of the Flemish self-awareness interferes, in the case of younger children, with the simple affective reaction to the "word" or "label." It is a fair assumption that the difficulties of ethnic and national labels and relationships are sorted out only at later ages when both kinds of national concepts—assignments and preferences—have become more firmly established.

The Glasgow children seem to react to a different kind of complexity by not showing a preference for their own national group. One possible reason for this lack of national preference may be that the phenomenon of the devaluation of ingroup which has been shown in many studies on children of minority or underprivileged groups exists here in a rather unexpected context. As the Scots are by no means a minority in Scotland nor are the intergroup tensions between the English and the Scots comparable to those of other studies on ingroup devaluation, the data we obtained may well constitute an important example of children's high sensitivity even to those aspects of social influence which remain fairly subtle.

Parents as Cotherapists in the Treatment of Psychotic Children

Eric Schopler and Robert J. Reichler

In the past three decades severely disturbed children have been exposed to a remarkable array of therapies, thus attesting to mounting interest in helping those children and understanding their disorders. Developmental therapy, discussed in this report, is a method in which parents function as the primary developmental agents for their own severely disturbed child. The goals are to prevent the elaboration of psychosis, to increase adaptation between the child and his family, and to promote recovery.

It is assumed that the directions of a child's development are based on the interactions with his parents. By and large, the normal child's behavior is shaped around parental expectations; the child in turn has an effect on the parent's behavior. The human infant is born with a biologically determined set of reflexes and responses that appear in regular sequence, and some of these responses are basic to social development. Some infants, for example, smile a great deal, whereas others smile less. For an autistic infant with impaired social responses, therefore, the interaction cycle is directed more by the biological limitations than it is for the normal child.

Several factors in the nature of childhood psychosis are important to developmental therapy: (1) the causes are multiply determined, (2) in individual cases the primary causes are usually unknown, and (3) it is likely that primary causes involve some brain abnormality.

New knowledge about the personalities of parents of psychotic children has been perhaps even more prominent in the evolution of developmental therapy than what is known of their children. Until very recently parents were generally viewed from the standpoint of psychogenic theories and were looked upon as primary causative agents for their child's disorder. Psychogenic theory, however, was perhaps a substitute for factual information. The theory has generated virtually no specific research explaining childhood psychosis, and its persistent application has evoked indignation against such unsubtantiated bias. It may also be implicated in social-political processes that appear to go against the best interests of the children. While parents of retarded children have long been organized to promote educational resources for their children, parents of autistic children did not form a national organization until 1964 when the psychogenic emphasis was challenged and the National Society for Autistic Children was founded.

Parents' aberrant thinking repeatedly has been linked to thought structure found in their schizophrenic offspring. Such "schizophrenogenic" thinking has been reliably measured in several studies. Recent investigations show that parents of psychotic children are disorganized in reaction to their disorganized, psychotic child.

The following propositions were derived as the framework for developmental therapy: (1) the causes of autism are as yet unknown, (2) the classification must therefore remain broad but descriptive, (3) the most likely causes involve biochemical and neu-

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rological brain abnormalities, (4) these result in perceptual inconstancies involving speech and communication impairment, and (5) parents' personalities fall within the "normal range," differing from the general population only in their perplexity and confusion about their unresponsive children.

Program Structure

Following a pilot study in 1966 using parents of psychotic children as cotherapists, a 5-year project was begun. Since it is only in its second year, some reported data are incomplete and are based on clinical observations. The structure for the program, however, has been established. Three main admissions criteria are used: (1) The child must have a diagnosis of autism or psychosis. (2) He must live at home in an intact family, with parents who are willing and able to participate in the Child Research Project. (3) He must be functioning on a preschool level.

Decisions for admission are made after a 2-hour diagnostic evaluation which, like all subsequent sessions with the child, is conducted in a one-way observation room. Both parents accompany the child for this session.

Diagnosis of psychosis or autism—An objective rating system has been developed for measuring the degree of psychosis found in each child referred with a suspicion of autism or childhood psychosis. Ratings of the young psychotic child may be grouped in two levels:

(1) *Specific Response Patterns*

Relatedness. There is an absence of age-appropriate attachment to people and sometimes a lack of attachment to objects or places. Perhaps because people are complex and changing, lack of social responsiveness is more frequent.

Speech impairment. Equally important, though developmentally subsequent to the relatedness impairment, is the absence, delay, or peculiarity of speech development.

Sensory peculiarities. These children show various expressions of unusual sensory processes. Nearly all tend to be inattentive especially to auditory and visual stimuli, and they sometimes show special sensitivity to selective sounds or to certain visual stimuli.

(2) *Other Characteristics*

The second level of psychotic signs includes peculiar motility patterns, abnormal activity levels, retarded intellectual functioning, mood changes, temper tantrums, and self-destructive behavior.

Parent-child interaction—Both parents are observed in an interaction with their child. This enables the staff to see the kinds of difficulties parents have interacting with their child, and it gives the parents an idea of how they will be expected to work with their child in the Project.

Staff background—All staff members function as therapists and parent consultants, though not usually with the same family. They are selected for their interest and skill in teaching autistic children and their parents rather than for their training in a specific discipline. Experience, enthusiasm, and willingness to learn have so far proven to be the best qualifications.

Parent Participation

Parents attend twice weekly for 45-minute sessions, with mothers and fathers usually alternating. During these visits parents may observe therapist's demonstrations, discuss problems with the parent consultant, or demonstrate their home program with the child.

Therapy demonstration — Parents observe through a one-way screen with their consultant, who focuses their attention on relevant aspects of the session. The demonstrations play a key

role in encouraging parents to apply child-rearing techniques in the special way required by their autistic child. The therapist acts as a model for general attitudes and approaches and demonstrates specific teaching methods. The therapist and the parent consultant agree on the session's focus prior to the demonstration, and the therapist shows how to make specific interventions appropriate to the child's development.

Home program—Parents are also given home programs which describe objectives, methods, and materials for working with the child in daily sessions. Content is based on the therapist's assessment of the child and the parents' experience at home, and both parents are expected to share in the home sessions. At regular intervals, parents demonstrate the home program with their child while therapist and consultant observe.

Generally the parents' daily home program sessions are more easily organized into an enjoyable and successful interaction than are problems in other areas of home life. To work out solutions to specific problems the parent meets with his consultant; problems discussed often involve issues not practical or feasible for handling during demonstration sessions, such as sleeping, eating, and difficulties with toilet training.

Parents are required to complete daily logs in which the home program is rated for changes in the child's responses, and once each week both parents rate the child's progress in other areas of home life. These logs form an important part on tracking changes and development in the child over time.

Research participation—Parents have been involved directly in research relating to therapy.

Without dichotomizing therapeutic structure as present or absent, the parents were involved in a systematic study investigating the effects of degree in structure on the child's functioning. Both parents and therapist were asked to alternate the structure in working with their child at 2-week intervals for an 8-week period. Interactions were rated by a time-sampling method. Results showed that the children were able to function more appropriately during structured than during unstructured sessions on all variables rated. It appears that the optimal learning for autistic children is one which has structure for acquiring new learning patterns which have not yet been mastered. The parents' direct participation in this study contributed to their interest and sensitivity to more accurate appraisal of their child's functioning level, and they used this information for finding and using appropriate methods of intervention.

Outcome Trends

Developmental therapy with parent-child interaction was begun 4 years ago, so there has not been sufficient time to complete longitudinal evaluation. In this beginning phase, however, we have some indication for the success of this process for both parent and child.

Among the ten families in the Project during the first 18 months, direct demonstrations were especially effective for parents at the lower educational level where verbal facility is limited. Although less verbal, these parents were capable observers and were effective in putting their observations to good use.

Parent involvement has been greater than anticipated, and attendance has been quite regular. Daily logs documenting the home program sessions have been maintained with high regularity. Mothers were more frequently involved in working with their

children than were fathers, though both participated. Often at the beginning of the parents' participation fathers were able to understand the child more objectively and to control the interaction more effectively than mothers. Improvement in the child, however, was more noticeable when mothers became more involved with the home program than when fathers attempted dominant involvement.

Recently a comparison was made between ratings on the child's activities during sessions with his therapist and ratings on the demonstration session of parents. Time-sampled ratings were made on the child's attention, affect, relatedness, verbal behavior, and nonpsychotic behavior. In spite of individual variation, there was a trend for parents to obtain higher ratings more frequently than did the therapist during the same period. This confirms our observation that parents often pull ahead of the therapist in their effectiveness in implementing therapy demonstration; nevertheless, parents continue to seek support for maintaining their efforts.

Many parents, especially mothers, have developed a degree of objectivity, investment, and skill found only in top-notch teachers. Our experience suggests that it is not only expedient to use parents to supplement the manpower shortage, but that they are frequently the most effective developmental agents for their children.

In addition to working directly with their own children, the parents in our program have recently organized their own State chapter of the National Society for Autistic Children. They have worked toward the establishment of special education programs for their children in the public schools. Through meetings with legislators, educators, and professionals, they have succeeded in setting up two demonstration programs for special education of autistic children. Parents have extended their capacity to bring more meaningful organization into their children's lives into the broader social implications of the disorder.

In all families, the parents' realistic appraisal of the child contributed to making their best energies available to him while maintaining or improving the adjustment among all family members. Attention to the coping abilities of families faced with a difficult problem releases resources, energies, and abilities which are often dissipated in enterprises that emphasize parental adjustment difficulties. It is time to recognize the autistic child's parent as the agent integral to the solution of his child's problems rather than as the cause of them.

The Family Life Cycle: An Orienting Concept for the Family Practice Specialist

CYRIL M. WORBY

The approval by the Advisory Board for Medical Specialties and the AMA's Council on Medical Education of a specialty board in family practice poses many opportunities and problems. One of these requiring major attention is the issue of what ought to be central to the family medicine curriculum. Although psychiatry and the social sciences will have important contributions to make to the core curriculum, it is difficult to know what may be most relevant from these disciplines to the practice of family medicine.

One of the important concepts receiving increasing attention in the literature on family process is the family life cycle. Viewing the family from the perspective of its life cycle may serve an important orienting and organizing function for the family practice specialist.

The concept of the family life cycle assumes that families tend to have a beginning and an end; that between these two points are a number of distinct sequential phases; and that within each phase are a number of phase-specific tasks. These tasks arouse considerable stress within the family system and require of all family members a continuous mutual and reciprocal set of readjustments.

The family practice specialist will be involved simultaneously with families who are at different phases in their life cycles. He will also, over a period of years, see a particular family through several phases in its life cycle.

It will be useful, then, to delineate those phases which most families go through and to describe what kinds of resolutions of the phase-specific tasks may be considered normative or growth-promoting and what kinds of resolutions may be considered deviant or growth-inhibiting. At the same time, it will be important to understand how the sequential phases of the family life cycle interlock and influence one another.

An appreciation of how a family meets phase-specific tasks provides the family practice specialist with a twofold opportunity: (*a*) a capacity to respond intelligently to the patient as an individual and as part of his family, and (*b*) a capacity for early recognition of deviant intrafamilial patterns.

Despite the considerable heterogeneity among American families, the family life cycle is arbitrarily divided into seven phases: formation of family, first child's birth, early individuation of first child, emerging sexuality of first child, first child's beginning school, first child's adolescence, parents alone.

Formation of family—Most families begin with a man and a woman joined in a union which is socially sanctioned. Intact families, legally sanctioned through marriage, will be the model throughout this paper, for discussion of family phases experienced by the nonintact family and by the "disadvantaged" family for whom basic opportunities are limited would be too speculative without the benefit of more extensive research.

One of the first critical normative tasks required of the newly formed marital pair is to begin relinquishing in one another that which is fantasy,

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ideal, or nonreal. The man must see in his wife less of his own parents as he knew them or wished them to be, and the wife must see in her husband less of her own parents as she knew them or wished them to be. Clearly, this is an ideal. We never totally see one with whom we are meaningfully involved in a fully realistic way. However, this task of not imposing too literally feelings and expectations from past important relationships (with parents) onto current ones (marital partner) is normally intrinsic to each marital relationship.

Another closely related task during this phase is for the newly married couple to achieve a satisfying and realistic relationship with the family each had left prior to entering the marriage. The fact of marriage does not automatically achieve necessary shifts in how parents and children perceive each other. These shifts demand reciprocal readjustments which can occur only over an extended period of time.

First child's birth—Integration into the family of the first child and coming to grips with the stresses inherent in the early mother-child, father-child, mother-father-child interrelationship constitute the next distinct developmental phase.

During pregnancy, following delivery of the first child, and into the first year of the child's life, all that has gone into the individual and marital lives of the parents becomes acutely relevant. The idea of motherhood and the idea of fatherhood are no longer abstractions but realities. The wife, who as a little girl rocked her doll in imitation of her mother, finds that the game is over. This is real. Is she adequate to the task, she wonders. And what of the husband? Can he share his wife with the child or does he become resentful and competitive, feeling that whatever the wife gives to the child is at his own expense?

Even at this early stage, the mother-infant-father triad share in a reciprocal relationship, and the birth of the first child acts as a stimulus for the parents to come to terms with a number of basic issues: How well crystallized is their individual sense of identity? How will the child alter their relationships with the grandparents? How will they singly and jointly relate to the child?

The infant has an enormous potential for growth and development; realization of this potential, however, requires a facilitating environment from the parents. Is the infant's world predictable? Comprehensible? Consistent? Gratifying? Besides getting a sense of the world through his parents, the child's emerging sense of self is highly dependent on how his parents experience him. The manner and extent to which the child utilizes his inborn equipment for receiving, experiencing, evaluating, and acting upon the world around him are likewise decisively influenced by his relationship with his parents.

Early individuation of child—Much has been written about the processes involved in the child's developing a sense of separate identity and on the impact of such strivings on the family. Clearly, this is an ongoing process, but it has been examined in most detail at two points in the family life cycle: during the first years of life and during adolescence.

Many factors will enter into the capacity of the parents to allow the child increasingly to explore and confirm his individuality as a separate person. One important factor will be the nature of the parents' relationship with one another. The greater the frustration experienced by the parents in the marital relationship, the greater the likelihood for displacement of

these conflicts onto the child by the parents.

The child's emerging sexuality—A complex set of reciprocal interactions ensues within the family as the emerging sexuality of the first child is experienced. The child wants to be like the parent of the same sex yet is simultaneously in rivalry with that parent as a consequence of feeling closeness to the parent of the opposite sex. For the parent of the same sex, there is the problem of controlling annoyance over the competitiveness of the child, while at the same time encouraging the emerging masculine or feminine behavioral roles. For the parent of the opposite sex, there is the problem of modulating feelings of attraction for the child, while at the same time being sufficiently responsive to encourage and value the developing sexuality of the child.

First child's beginning school—With the beginning of school, the child physically separates from home and mother for extended periods of time. Major readjustments again are necessary. The child, mother, and father are required to accept the teacher as a surrogate parent. For the child there is need to adjust to peers, to accept increasing structure and control, to acquire knowledge, and to integrate the contradictions posed by differences in the home and the school environments. During this phase parents can help the child bridge or widen the gulf between the world of the family and the world outside.

First child's adolescence—Interrelated physical and psychological changes in an adolescent family member again confront the family unit with a need to work through issues of sexuality, role identity, dependence, and independence. A basic task in this phase is for the adolescent and his family to disengage from one another without a sense of impending catastrophy, either for the adolescent or for his parents.

The parents alone—We have now come full circle. The young adult leaves his original family to begin one of his own. For the parents, this phase is a particularly poignant one. They began alone, and they are now alone again. Will they envy their children's youth, vigor, and promise of the future? Or will they reinvest in themselves and in one another with a genuine feeling that there is much promise for them in their own future?

All families change over time, and some phases of the family life cycle are common to most families within a particular subculture. As is the case with individual development, the points of transition between one phase and the succeeding one represent for the family unit a time of considerable stress. These points of transition may be viewed as normally occurring crises, since the adequate accomplishment of the tasks intrinsic to each new phase rests on how well the tasks of the preceding phases have been met.

Through an understanding of the special characteristics of each phase in the family life cycle, the family practice specialist will be in a unique position to detect maladaptive individual and family patterns early in their manifestations, and render help in an important and meaningful way.

Introducing New Educational Game Principles: A Case for Education and Behavior Engineering

LEE A. FRIEDMAN

The time has come to contest and alter, as acceptable and satisfactory educational media, the honored provinces of textbooks, lecture, and other unsystematic multi-media potpourri. These techniques are incapable of satisfactorily preparing today's youth for life and labor. The pressures of a rapidly changing socio-technological world have been draining our traditional educational tools and magnifying the education institution's hidden weaknesses—its inadequate aid in the attainment of practical skills and educational goals, and its hampered ability to effectively accommodate students to societal obligations.

The Engineering Approach

Two steps are needed to ameliorate flaws in contemporary educational methods and media: (1) augmentation of existing educational principles, and (2) concomitant changes in educational methods and media.

Step 1—The augmentation principle introduces the functions of applied systems science and engineering technology. This technology performs an important function—selecting and constructing means that can control human and material processes and activities to ensure the achievement of some practical purpose or value. Developing the means for control is the key principle, and the means are determined by introducing and manipulating *applications* of independent variables that are linked by scientific experience and supposition to the dependent variables. In this manner the engineering approach can effect and/or forecast a particular end.

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For illustrative purposes, the basic engineering procedure using a single independent-dependent variable dimension may be viewed in this paradigm:

Specify an objective or the applicable dependent variable.	Ensure the acquisition of specific knowledge with minimum forgetting.
Link the objective to its applicable intervening variable.	Learning, motivation, etc.
Define the scientific theories/laws predicting that which is implied by the intervening variable.	Learning or reinforcement theory (also personality dynamics, role theory, psychophysiological theories, cognitive theories, etc.).
Analyze theory and determine the independent variables associated with objective (link the constructs).	Immediate reward or positive reinforcement effects an increased learning curve. (Conformance to role expectations, frustration leads to aggression, memory spans and processes, etc.)
Develop engineering requirement that will satisfy concept of "immediate reward."	Require immediate feedback on individual responses after presentation of information to be learned.
Develop engineering specifications and applications.	Specify how and when feedback is to be presented and its contents (a scoring mechanism, a loss of position).
Evaluate (experiment).	Test the effectiveness of feedback mechanism devised as means for aiding subject learning and retention. Modify if necessary.

The advantages offered by applied system scientists for the development of new educational tools are twofold:

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They know basic scientific theories and techniques of research, and they have been trained in the art of applying these to solve practical problems. In many respects they have divorced themselves from the artificial restraints of their original (parochial) field of study, having learned by necessity of the interrelatedness of fields of knowledge. They interpret the multifarious influences evident in a target situation and then, by design, reconstitute pertinent people, procedures, tools, policies and organizations into a holistic entity; in this way these scientists *create* a new social subsystem.

Step 2—Recommended engineering technology will introduce methods to simulate life situations via the media of game play; the engineered games will provide the means for learning subject matter, for rehearsing or exercising knowledge applications, and for enabling students to actively participate in the educational process.

Simulation

Principles of simulation specify the use of engineering surrogate situations which correspond to and represent a real-life referent target situation. Simulation, to be effective as a pedagogical method, requires purposive incorporation of representative physical, psychological, cultural, and institutional attributes existing in a selected real-life target situation.

Simulation has numerous inherent advantages for education and learning: It is make-believe, thus inducing achievement motivation and stimulation to participate; and it increases social freedom, suppressing the harsh consequences of reality. It introduces representative portions and attributes of real-life situations when these situations are not readily available for participation. It introduces inexperienced participants to the expectancies of real-life situations. It permits control and regulation of stimuli, variables, and participants to ensure achievement of objectives and to reflect the nature of real situations. It supports "refresher" courses for those practitioners whose proficiency levels have dropped below a required norm. It permits introduction of varied subject fields and allows learning to be self-pacing or forced pace.

Simulation can take many forms—the use of segments from real-object systems, e.g., an automobile trainer with correlated movie films projected on a windshield screen; or the inclusion of artificial/analogous situational systems, e.g., business games played on a computer or on "boards."

Game Play

The game, and game play, fulfill all of the requirements of simulation and engineering technology, since the game with its contents and dynamics can be constructed to simulate and control the activities and participants of a situation and its outcome. (The structural forms of the game can include board games, computer games, social interactivity games, tools and instruments, toys, cards, dice, etc.)

The educational game offers several advantages: It may be used to teach functional (rather than parochial) subject matter. For example, trigonometry, geometry, physics, mechanics, rules of the road, and communications, could be learned while playing a game of "transportation" in which the language, theorems and principles of navigation, aerodynamics and the codes of society were part of the game process. It permits students to participate actively in the situational process, as they might in real life. The game may include attributes that control the achievement of specific objectives: attributes based on what the school wants to teach; what the needs, requirements, and capabilities of the stu-

dents are; and what societal institutions want in the way of an educated individual. Results of player actions, decisions, and strategies are fed back to him and to the teacher, indicating immediately the degree to which knowledge and experience has or has not been acquired. Even before the game play has ceased, the student can correct his erroneous notions.

The Reality Concept

As an abstracted representation of some segment of reality, game attributes are momentary re-creations of reality attributes, but reduced to controllable dimensions. In order to be a game and not reality, the scale on which the demands of competition, cooperation, role playing, and accomplishment occur is reduced, permitting the players to handle such demands at their own time, space, volitional, and capability levels. This compression of reality speeds up and reinforces learning by making the constituent attributes emotionally comprehensible and acceptable.

Game Attribute Requirements

Certain attributes necessary for satisfying the preceding functions for educational games must be identified. They are specified here as game design requirements—for effect and for play. Although these attribute requirements are analytically categorized, the attributes are highly interrelated. All the stipulated requirements will not be pertinent to a specific game (or toy); criteria for inclusion depend on the players' levels of mental and physical development, the characteristics of subject matter, and the demands of the referent situation.

Design For Effect

Group characteristics—Game and toy design should be influenced by the social, psychological, cultural, and environmental characteristics of prospective players.

Character growth—Game and toy design should provide for the development of good habits and character formation, such as orderliness, cleanliness, sense of responsibility, respect for property, independence, self-control, and determination.

Ego satisfaction—Game and toy design should provide means for satisfying personal needs and motivations; each need and its degree of application must be contemplated in terms of the players' level of development and the referent situations.

Social achievement—Game and toy attributes should involve achievement models and enhance and promote social development and personality adjustment.

Education—Game and toy design should include academic subject matter—information and associative processes—as central situational themes to promote the acquisition of knowledge.

Physical/Motor skills—Game and toy design should provide stimulation for the development and reinforcement of physical/motor skills.

Intellect development—Game and toy design should provide the means for developing such capabilities as analysis, synthesis, memory, volition, attention, reason, recognition, recall, anticipating, and planning.

Sensory development—Game and toy design should provide the means for sensory development through the proper use of color, shape arrangement, movement, dimension, texture, and illusion, based on the physiological capabilities of prospective players.

Design For Play Stimulation

Enjoyment—Game and toy design should maintain a built-in pleasure principle to ensure enjoyment and the desire to participate. This requirement is couched in the concepts of winning and accomplishment. Thus, for example, games or toys should include,

when possible, variations in which winning and losing are interchanged and their intensity increased by the instability of sides, total failure probabilities and lack of satisfaction are reduced, and accomplishment motives and curiosity factors are increased. (Curiosity is induced, for example, by hiding an opponent's first three moves.)

Stimulation—Game and toy design should provide players with proper motivations to participate through the implementation of (a) chance factors, (b) rationed success experiences, (c) role playing, (d) identification, (e) cooperation, (f) contest, and (g) goal attainment.

Explicit closure—Game and toy design should provide definite terminal states according to defined sets of rules, moves, and alternatives. These terminal states are definitely related to such things as feedback for closure and certitude, success experiences, feelings of satisfaction, and reduction of disruptive emotional states.

Fad following—Game and toy design should consider long- and/or short-term fads or trends found prevalent in the group structure. Heroes, clothing, animals, the current rage for self-testing, the emphasis on the self-made man, or the prevailing type of political integration in a subculture should be considered.

Feedback and feedforward—Two keystone mechanisms support the ultimate utility and efficiency of game play: *Feedback*—a technique that effects the reporting of immediate situational or system reactions to human performance. Feedback messages, formal or informal, should indicate to the player his deviations from some standard and the corrective activity to be applied. *Feedforward*—a predictive technique which reports the consequential or (future) anticipatory reactions by the situation or system, calculated from current human performance. Feedforward messages should indicate to the player where his current activities, decisions, and strategies will take him.

Critical Game Design Determinants

To identify which requirements are pertinent to the development of a specific set of games, the designer must consider certain human performance criteria. A major group of game process determinants includes the physical, social, and mental development levels of the prospective players.

2 to 3 years old—Games and toys cannot include chance or competition factors. The child at this age cannot comprehend the concept of chance, and he has little desire for prolonged interactive play. There is a greater need for constructive, destructive, and manipulative requirements for development and use of large muscle coordination.

11 to 13 years old—By this stage, the individual needs games which require him to plan and anticipate with some skill. Chance factors are appreciated more as a diversion than as a critical constraint. The need for competition and group loyalty is growing and requires reinforcement and practice. The individual at this level will practice social skills heretofore weak or lacking. Sex difference in role playing is critical.

Adults—By this stage, game requirements are correlated less with physical and mental development stages, which have reached a plateau, and more with psychological, social, economic, and political status and accomplishment. For example, among males who identify with the values and ethos of the lower socioeconomic-cultural sphere, where societal rules and conditions for middle-class status ascription are rela-

tively ignored, a preference exists for games involving a high degree of chance with a concomitant low regard for social achievement games. Hence, success experiences are measured by these players in terms of luck and risk, rather than knowledge and strategic planning, and in terms of individual success rather than group success. There are also other subsets of adult activities, environments, and value systems that require separate emphasis to determine game requirements (for example, senior citizens and people in confined or isolated environments, such as military personnel, prisoners, seamen, and hospital patients).

Ensuring the attainment of the objectives outlined will require building bridges connecting academic science, applied system science, engineering, educational institutions, and other applicable societal institutions, with the students. In the first relationship especially, applied system science has been constrained for the most part by the meager contributions of the academic sciences to advance engineering states of art. This means that applied science cannot develop new systems of control that might require them to advance beyond the last scientific hypothesis tested. The lack of pertinent experimental tests is a roadblock that system science can hurdle only by having academic science answer engineering queries.

The need for educational change should be apparent. Society can ill afford the disruptive activities of what some people may call a minority of students. The responsibility of the education institution to prepare its students for a lifetime of obligations cannot be forsaken. The home and family, the only other influential institution available during the formative years, cannot be expected to be purveyors of knowledge. The family institution itself presents critical situations about which the student should be informed. The general conditions of anxiety provoked by the dynamics of a generation gap, even for those supposedly overt "good" and "motivated" students, should not have to exist. The minor culture shock they often manifest and endure after being graduated from or dropping out of school to work in business, industry, and in medical and psychology clinics must surely be a warning sign that many students lack adequate preparatory experiences and knowledge. Do they have to be re-educated to overcome their disappointment when the beautiful theories from their texts are murdered by brutal facts?

Sesame Street: Shaping Broadcast Television to Needs of the Preschooler

EDWARD L. PALMER

After a year of programing, the first experimental phase of the Children's Television Workshop is over. CTW was created early in 1968 with a mandate to produce, promote, and evaluate a series of hour-long daily television programs for the instruction and entertainment of preschoolers. Our sponsors and for the most part the program's large public have pronounced the experiment a success. The results of a major national program of achievement pre- and post-testing, carried out independently by the Educational Testing Service of Princeton, New Jersey, further affirms the potential power of broadcast television as a medium for instruction.

From the outset it was decided that educational researchers would work in tandem with experienced television producers to determine the format and content of the program and to keep under constant review the impact of the program on the audience. Our job was to discover a fit between television and the preschoolers we aimed to reach, particularly those in the ghettos of the inner-city. Television could be shaped to its audience of children, and *Sesame Street* was an evolvable program capable of being altered in accordance with the needs of the audience, as we perceived them, and in response to our education goals.

Our first efforts to match show with audience lasted through a year and a half of prebroadcast research which concentrated on finding what techniques of programing most appealed to young children. The broadcast guidelines told us preschoolers enjoyed fast-paced action, novel and humorous situations, and great variety. Animation, other young children, animals, puppets, and warm, friendly adults were among the most successful targets of their attention. Variety was the key technique in capturing the attention of children. Even fast-action segments would retain children's interest for longer periods if woven into sequences in which the pacing was varied.

Our research taught us that while children in the 3-to-5-year-old group respond well to word play, they do not respond to plays on words, and they are generally incapable of dealing with the double meaning of puns. We use word play for the sheer enjoyment it gives children. Alliteration is useful in focusing attention on initial letter sounds. Rhyming, large words, and nonsense words all appeal to the auditory delight of children. Whatever use we make of puns is mainly to capture the interest of older sisters and brothers, or even parents, who often hold the upper hand in controlling the television dial.

We have never felt that television did a particularly good job of story reading on the set. Books should be dealt with as books, not as animated television plays. Otherwise, there is the considerable likelihood that the young viewer will fail to make the connection between the pleasure of hearing the story recited and the enjoyment of the act of reading per se. Straight readings of the text have been discarded in favor of

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starting the story as a reading and shifting quickly into a less formal sort of recitation.

In our use of the Muppet puppets we have tried an enormous range of approaches (i.e., a mock quiz show, mock operas). Our producers created a character called Granny Fanny Nestlerode to handle the "Dear Abby" sort of problem letter. Granny Fanny's solution is generally so absurd as to encourage the children themselves to come up with a better idea. Many children become so involved in such situations that they call out their own ideas for solving the problems.

The magazine format, in which we can insert new segments and delete others, allows great flexibility. It is highly significant from the research standpoint that we can always remove a section of the show if it fails to work and still preserve the integrity of the show as a whole.

Certain repeatedly used general formats vary in their specific content from show to show. In some cases, elements of these general formats are used to convey learning material. We use format itself as a teaching tool. We use format elements of all kinds as "conceptual bridges" to put the children immediately in mind of what we are teaching—visual bridges, catch phrases, and so forth. We are even using music as a bridge. If one piece of music is used invariably when the concept of sharing or cooperation is about to be introduced, for instance, the children, through the commonality in the musical background, will be instantly in tune with the subject matter.

In another case, we use a sorting song, "One of these things is not like the others," along with a graphic display of four objects, one of which differs from the rest in size, form, function, number, or class. We combine the song with the particular graphic display to impart the basic concept of sorting, then we retain one strong format element, the song, and apply it to new arrangements and displays of pictures or objects as a way of attempting to help the child generalize the sorting skill.

We have observed several bonus features which television provides for a show aimed at instructing young children: it is noncompetitive and nonpunitive. A child can deal with the show at his own level of ability, without the classroom learner designation of slow, fast, or average. The same segment thus serves different functions: a repeated segment might supplement one child's knowledge of numbers, for example, or provide sheer entertainment or practice for another child who already knows the material. While teaching one child for the first time, it may fail to interest another child altogether. In that case he always has the option of turning away. At whatever his level of reception the child is neither punished nor graded.

The Workshop's staff of educational and psychological researchers has carried out studies of achievement in relation to the number and the schedule of repetitions of individual instructional segments; various uses of descriptive language; the use of explanations prior to or following pretaped or prefilmed segments which would be difficult to understand in isolation; and the use of techniques for eliciting verbal or motor participation on the part of the viewer. Some of the principal findings were that: children who watched the program showed greater learning gains than children who did not, regardless of socioeconomic status; children who watched the show most gained the most; disadvantaged children who watched the show fre-

quently made gains surpassing those of middle class children who watched infrequently; and 3-year-old children had greater gains than the older children.

Our perceptions concerning the nature and needs of preschool children are not held universally among specialists in early childhood education. Though the questions and criticisms from either traditional preschool educators or others have been surprisingly few, it might be useful, now that our second season is underway, to review some of them.

How can one program serve an audience that consists of children of different ages and differing levels of educational receptivity and attainment?

The very flexibility of our format permits changing needs to be met and children of different age groups and levels of learning ability to be reached at the same time. Largely this flexibility comes from the show's magazine format—the departmentalization of the program, its use of discrete and interchangeable learning units. We don't expect all parts of the program to be understood equally by all age groups in the audience, although we do hope the program holds sufficient attraction to keep all interested watching.

Wherever possible, instruction and entertainment segments have been pitched to multiple age and learning levels. If any complex learning task is reduced to components, one can identify distinct levels of intellectual difficulty in the concept. All these various levels of intellectual difficulty may be present within one short animated sequence featuring the "lecture" of a character. The younger child may comprehend only the simplest level of the lecture. With repetition, however, he may come to attain the level at which an older child started.

Some educators feel that too many short bursts of information minimize understanding and tend to fragmentize the attention span of children, interfering with their concentration.

Most segments, though brief, were designed to contain more information than the child could grasp in a single exposure. They were designed for repetition, and because of the exact repetition made possible by television, the child could gradually acquire a comprehensive understanding of a complex segment which he would be unlikely to acquire in a single exposure. In short, we believe the repetition factor works for us as a means of helping the child to perceive continuity and coherence in segments which would otherwise be perceived as a succession of fragmented and episodic impressions. We have observed that repetition does not diminish the child's interest in the show. With repetition the presentation of information may well work to increase rather than diminish the preschool child's span of comprehension.

In the absence of two-way communication, how can television make up for a lack of individualized instruction in which a child receives a check on correctness?

Sesame Street was not intended to duplicate or take the place of the classroom experience of interaction between teacher and pupil. However, in some features of the program, we have succeeded in establishing a kind of two-way communication with our audience. In one unusual segment designed especially for the program, the alphabet is recited by the actor James Earl Jones. He adopted a special style for reciting the letters: slow, solemn, painstakingly distinct. At first a group of children under our regular observation responded by repeating each letter after Jones. As the segment became more familiar they tried to say

the letter in unison with Jones. Still later they began to anticipate him, using his sounding of the letter only as a check on accuracy. Unwittingly we had developed a simulated version of information feedback similar to that of a two-way communication system. It now appears that wherever the viewer can be induced to form an hypothesis which is later confirmed or denied on the screen, the learning experience involved is equivalent to that gained through actual two-way communication. Though this is not the kind of learning a child experiences in first-hand encounters with the environment, it is active learning in an intellectual sense.

Does this receptivity to the program vary widely in different group viewing situations?

From program comparison tests we know that for audience attention *Sesame Street* will compete with anything on television. But the behavior of a group is often related to the attitude of the teacher or adult present at the time. We may surmise that if parents and teachers are indifferent, children often will be inattentive. But if the adult is enthusiastic, and encourages the child to view the program, the child is likely to respond.

Though the program's stated purpose is to teach various complex reasoning and social skills as well as letters and numbers, isn't the rote learning of the latter overemphasized?

While the letters and numbers were indeed selected for special treatment, the emphasis may appear to be greater than it actually is because of the salience of the graphic symbols in the presentation of the material. There is no counterpart to these familiar, recognizable elements in the reasoning or social or attitudinal domains which are treated in many segments. A related point is that the letters and numbers are not taught solely as ends in themselves. The emphasis on them follows in part from the view that young children will learn them quickly, will promptly exhibit this learning, will be rewarded by their parents and teachers for doing so, and will experience enhanced self-esteem as a result.

While educators rightly place a premium upon goals which involve complex conceptual processes, some rote learning relating to the letters and numbers is essential and is best acquired early to avoid the failure and frustration which too frequently accompany the child's first encounters with reading and arithmetic. One of the many strengths of television as an instructional medium may be its capacity to produce simple learning in a nonpunitive manner.

The child is immersed from birth in the spoken form of the language, and it is not a problem to him. By contrast, when he first tackles the written form of the language in school, especially for the disadvantaged child, it is an abrupt confrontation. Basically, from a developmental standpoint, there is nothing to impede the young child's ability to deal with the written form. *Sesame Street,* with its graphics and recitations and especially with its light and playful treatment of them, tends to immerse the child in the written form in much the same way in which children always have been immersed in the spoken language.

Sesame Street has tried to approximate or re-create the easy, casual environment of the child's natural learning experience of the spoken language. Its greatest impact, in fact, may well be in providing for the gradual introduction of the language in its written form in a context which is not only nonthreatening and nonpunitive, but is also light, entertaining, and fun.

The Measurement of Perceptual-Motor Abilities of Head Start Children

George Gordon and Irwin Hyman

Recent years have seen a rapidly expanding interest in the early educational development of economically impoverished children, and, as a result of this interest, numerous programs for dealing with the problems of these children have been proposed. However, the production of such programs has been impeded by the lack of available data and instrumentation appropriate to this group. The major purpose of this study was to develop a battery of perceptual and perceptual-motor integrative tasks that would be appropriate for administration to young disadvantaged children. Briefly, the child is presented initially with simple perceptual tasks involving single sensory modalities. The tasks are gradually modified to call for more complex perceptual skills and the integration of perceptual and motor abilities. The underlying rationale postulates a developmental sequence from the basic perceptual skills utilized in form recognition through two paths that lead ultimately to writing and reading.

The development of the series of tasks was part of a larger study and, as such, was designed to serve two functions. The long-range objective was to provide measures of perceptual functioning for the more comprehensive longitudinal study in order to test the relationships between the hierarchical model and educational development as the data became available. The more immediate objective was to develop the instrumentation for a descriptive study of perceptual variables in order to provide further guidelines for current educational research and practice with disadvantaged children.

The subjects were 168 children, 88 boys and 80 girls, ranging in age from 4 to 7½ years. They were enrolled in 12 classes in the summer 1968 Head Start Program. Almost all the children were from families qualifying under the Office of Economic Opportunity guidelines, which prescribed a maximum income of $3,000 for a family of four.

In choosing and developing various instruments, an attempt was made to measure skills from the simplest types of perceptual recognition to those tasks requiring integrative abilities. Ten tests involving visual perception and four involving auditory perception were utilized.

The first seven tasks in the visual mode employed the 10 forms in the Seguin-Goddard Form Board and six additional forms developed by the present authors. The other three visual tasks are parts of widely used tests involving the use of paper and pencil. Three of the four tests in the auditory mode were available instruments, and the fourth (Oral Sequencing) was developed specifically for the study. The following is a brief description of each of these measures:

1. ***Three-dimensional Form Discrimination.*** The child is presented with two three-dimensional geometric forms and asked whether they are the same or different.

2. ***Three-dimensional Multiple Choice Form Discrimination.*** The child is presented with a standard three-dimensional stimulus form and choices numbering progressively from two to five forms. He indicates which of the choice forms is the same as the standard.

3. ***The Seguin Form Board.*** The two scores are the fastest time of three trials

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in seconds and the total number of errors in the three trials.

4. *Two-dimensional Form Discrimination.* Identical to Test 1 except that the forms are two-dimensional line drawings of the faces of the three-dimensional forms and are reproduced on cardboard strips.

5. *Two-dimensional Multiple Choice Form Discrimination.* Identical to Test 2 except that the forms are two-dimensional representations as described in 4.

6. *Two-dimensional Discrimination of Rotations.* A printed standard stimulus form consisting of a two-dimensional line drawing of a form is presented along with a response strip that contains four drawings, one of which is identical to the standard, while the other three are the same form rotated into three different positions. The child indicates which of the response forms are in the same position as the standard stimulus.

7. *Form Memory.* The materials are identical to those of Test 4. The child is shown the stimulus form for 5 seconds and is then requested to recall it by pointing to the same form among the two to five alternatives presented on the response strip.

8. *Form Reproduction.* This is the Geometric Design subtest from the Wechsler Pre-school and Primary Scale of Intelligence.

9. *Form Reproduction.* This task requires drawing the forms on cards one, four, and six of the Bender Gestalt Test, plus a cross with all lines equidistant in length from the point of intersection.

10. *Fine Motor Coordination.* This is the Eye-Motor Coordination Test from the Frostig Developmental Test of Visual Perception.

11. *Hejna Developmental Articulation Test.* The three scores consist of the number of sounds articulated correctly in each of the three positions.

12. *Wepman Test of Auditory Discrimination.* The score is the number of pairs on which the child gives the incorrect answer.

13. *Haskins pb Kindergarten List.* In this test, the examiner reads a list of 50 single-syllable words that are phonetically balanced for the English language. The child repeats each word after it is given, and the score is the percentage of words he repeats correctly.

14. *Oral Sequencing of Single-syllable Words.* Sixteen series of one-syllable words ranging from two to five words per series are read by the examiner. The child is required to repeat each series of words after it is given, placing the words in the correct sequence. The score consists of the number of series correctly repeated as weighted by the number of words in each series.

All children were tested in at least two sessions by two different examiners. The examiners were, for the most part, graduate students in the areas of special education, school psychology, and clinical psychology. Graduate students in speech pathology, speech therapy, or audiology, all with professional experience, administered Tests 11 through 14. All examiners were given specific training for their portion of the battery. Whenever possible, sample items were used to determine whether the child understood the test directions. If on the practice items it appeared that the child did not understand the instructions, additional coaching was included in the directions. Examiners kept anecdotal records of unusual occurrences and of those children who did not appear to comprehend the concepts involved in the instructions.

Relatively more errors were made when the concept of "same-not-same" was used, as in Tests 1, 4, and 12, than with tests that required matching to sample, such as 2 and 5. Although its was hypothesized that the greater number of stimuli in the latter tests would make them more difficult, it appeared that the more complex directions of the former tasks had the greater impact.

Although the percentages for the visual tasks 1 and 4 were high enough to be of considerable concern in any testing program, the percentage was almost twice as large for the auditory task 12. Most of the reliability estimates were too low for making individual decisions, but most were sufficiently high to be useful in making group comparisons. Also, the lowest reliabilities were obtained with proto-

type instruments that were uniformly short and restricted in range.

In order to explore further the relationships among the measures, a correlation matrix based on all possible complete pairs of scores was computed and factored by the principal components method. The criterion yielded six factors that accounted for 71 percent of the total variance represented by the 18 variables included in the analysis. In this analysis. the age of the children was included as an additional variable. The following is a list of the variables that were the major contributors to each of the factors: Factor 1 —all the straight mimicry tasks in which the child is required to reproduce a sound he had just heard; Factor 2— closely related to age, consists mainly of those tasks requiring the child to use paper and pencil; Factor 3—two different Seguin scores that are also related secondarily to the Bender score; Factor 4—two multiple choice formats of the visual discrimination tasks; Factor 5—loaded most heavily with the "same-not-same" formats of the visual discrimination tasks; Factor 6—defined primarily by the auditory discrimination task, with secondary loadings for the oral sequencing and rotation tasks.

Tests 1, 2, 4, and 5 involved form discrimination of configural differences and differed in the dimensionality of the stimuli and the form of instructions. However, the four tasks did not form a discrimination factor, but rather loaded on two separate factors. This occurred despite the fact that mean performance was uniformly high across all four tasks. The existence of Factor 4 and Factor 5 suggests that the format of the instructions had more to do with performance than did the number of dimensions of the forms. It appears that somewhere between the ages of 5 and 6 the children's performance approaches the maximum. For the multiple choice condition, this maximum performance appears to be reached somewhat earlier.

Examining the performance on the form board, which can be administered nonverbally, these children are comparable to the children in the original norms group. The factor analytic results indicate that some of the same integrative skills required in the reproduction tasks are also part of the form board task, but probably at a simpler level. These findings thus support the use of the form board for lower-class children as a measure of motor speed and visual-motor integration.

The rotation task presented more difficulty for the children than the discrimination task and fairly distinct improvement in performance occurred at about age 6.

Performance on the memory test (Test 7) was consistently lower than on the comparable discrimination task (Test 5) across all age groups, and a considerable improvement in performance was noted around age 6. There was considerable variability in performance for the memory test. This variability in short term visual recall has significant implications for the differential "reading readiness" of young children. The memory test did not load substantially on any of the factors indicating relative independence of memory from the other skills tested. It would thus appear that in measuring prerequisite skills for a task involving a memory component, it would be necessary to have an independent measure of this variable.

The form reproduction tasks (Tests 8, 9, and 10) all loaded on Factor 2, and each elicits considerable variance within the sample. The group as a

whole scores significantly lower than middle-class groups.

The mimicry tasks all loaded substantially on the first factor. The Developmental Articulation task shows a slight but fairly consistent developmental trend. It might be noted that among those children 6½ and older performance falls off, indicating that this type of task may be sensitive to the identification of learning disabilities. With the preceding exception, most of the children in the sample performed at levels consistent with those of middle-class children.

The results indicated that it is possible to develop a battery of perceptual-motor tests that are appropriate and economically feasible for large-scale screening of preschool children from economically impoverished backgrounds. Some such instruments already exist, while others show considerable promise for further development.

Some of the results suggest interesting theoretical and practical implications amenable to further study. One such result is the similarity of loadings of rotation, auditory discrimination, and oral sequencing on the sixth factor. While the first two tasks have severe limitations, results suggest the possibility of some common integrative factor related to concept formation that may appear as a deficit in these children.

The high correlation between the scores on copying tasks (Factor 2) and age supports the concept of a strong developmental aspect for the skills involved. Further, the strong loadings of the three tests on a single factor suggest that any one of the form reproduction tests would provide a measure of the abilities involved.

This study demonstrates the feasibility of large scale screening for the early identification of perceptual and perceptual-motor integration problems within this type of population. To the degree that these problems determine future educational deficiencies and are amenable to remediation, such screening is of vital importance. More knowledge in this area is particularly important in relation to recent suggestions about cognitive abilities of specific disadvantaged groups. This revival of the nature-nurture controversy and the suggestion that development of "associative vs. conceptual" learning ability may be quite different within a lower-class population may lead to further rigorous research into the variables that determine early educational development.

Short-Term Treatment in Child Psychiatry

JEROME D. GOODMAN

To meet community needs as effectively as possible, child psychiatrists are now spending less time in clinical "one-to-one" settings and more time in consultation, supervision, planning, administration, and broad areas of education and research.

Despite the shortage of professional manpower, there are some hopeful aspects to the situation. Most patients referred to the child psychiatrist have mild and often transient problems. Since emotional problems in childhood are generally caused by a disturbance or an arrest in maturation and development, simply removing the retarding influences will often allow children to recover. Furthermore, young children are far more resilient than adolescents or adults and can recover more quickly when pathogenic stimuli are altered. Finally, many children can benefit from the intelligent use of psychoactive drugs. Recognition of these factors has led to the increasing use of short-term treatment.

There is general agreement that the diagnostic process in child psychiatry is in itself therapeutic for the child. Diagnosis permits the parents to express their concerns and allows the child to perceive that his inadequacies and discomforts are not a cause for ostracism but instead have led his parents to seek help.

Successful results in short-term treatment depend on careful diagnosis. If the diagnostic process is painstaking and the therapy is sharply focused, treatment is often short and effective.

Child psychiatrists must resist the tendency to diagnose children pragmatically. Pseudo-pragmatic diagnosis may succeed in placing children in special classes, but ultimately it compounds the basic problem. The number of children who have undergone prolonged psychotherapy because of errors in primary diagnosis is alarming.

Child-focused Psychotherapy

Child-focused psychotherapy takes many forms; all are based on the general principle of entering into the child's domain and lending the strengths and skills of an interested, objective, and experienced adult. New solutions are offered to old problems, including the child's need for close companionship, his concerns about basic security, and his strivings toward independence and maturation as alternatives to regression and infantilism. The actual work of therapy is accomplished through human interaction. Various play devices are merely facilitators. Materials which invite imaginative manipulation are more versatile than standardized toys.

Group therapy for children is becoming more popular, as interaction with other children provides an ongoing opportunity for selective treatment. The therapist should be familiar with each child individually, so that group therapy is not used as a means of saving professional time but as a treatment of choice to bolster peer interaction. Often group work can complement individual therapy, thus offering another dimension to the continuing opportunities for modification of behavior.

In all types of psychotherapy for young children, the parents are seen periodically. The parents—as primary educators, therapists, authority figures and love objects—are critical to the

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success or failure of the treatment program. The child psychiatrist provides a corrective encounter for the child and presents him with alternative means for coping with problems. Once another activity becomes as important to the child as the therapy session, the therapist is wise to withdraw from regular contact with the child. Treatment must not become, in itself, a problem that conflicts with healthy play and growth in peer relations.

Drug Therapy

Drug therapy for children is gaining impetus. The use of amphetamines and antidepressants for learning disorders and the hyperkinetic syndrome often results in dramatic improvement. In hyperkinetic disorders, some clinical principles work well: The closer the hyperkinesis presents to classic brain injury, the more effective are the amphetamines. The fewer the signs of organic pathology, the more useful is methylphenidate.

The efficacy of phenothiazines for psychotic behavior seems less correlated with diagnosis than with target symptoms. Thioridazine is the most useful medication for the younger child who does not relate well, who is bizarrely overactive and whose vital functions are disturbed. The use of imipramine for enuresis is fairly well established but should be reserved for children who are at least 7 or 8 years old.

Electroencephalograms have been found to be increasingly useful. Still many children with borderline tracings and equivalent seizure patterns go unrecognized. For many children with borderline wave-pattern abnormalities, diazepam is useful. Unfortunately, a number of children who respond well to diazepam and its close congener, oxazepam, complain of vivid dreams. The empiric use of diphenylhydantoin for children is not advisable unless the electroencephalographic abnormality is clear. Many children with behavior disorders respond poorly to this medication and may have untoward reactions.

All children who receive medication should be periodically re-evaluated. The physician can observe changes over time and chart the developmental progress; also followup visits provide an opportunity for continued parental counseling.

The child should also be seen regularly by the family physician. Dosage adjustments are more critical for children than for adults. Laboratory examinations are routine but are not a substitute for periodic physical examinations. In all children receiving medication, the least reliable informant about progress is the parent. The teachers's report and the family physician's clinical impression are more significant.

Counseling Parents

In some areas of the United States, the child psychiatrist is re-educating the public through counseling with parents. Three themes recur frequently:

Modesty and the need for children to develop independently—There are still many parents who have the misguided notion that things of the body are best left natural and that physical modesty is an outmoded concept. These attempts to ignore the sexual aspects of the body often represent parental needs to infantilize the children. The continuing trend of earlier arrival of pubescence in girls and boys has compressed childhood and expanded adolescence, with all the attendant psychologic implications. Children must be granted the right *not* to be exposed to sexuality before they are psychologically equipped to experience it.

The need for education in adminis-

tering discipline—Here, only broad guidelines are necessary and these can be individualized. The following disciplinary guidelines are usually applicable in counseling:

(1) discipline should be administered after the act rather than before it has occurred—the parent should not threaten or make bargains with a child about future behavior; (2) children should not be given a decision-making role too early; (3) discipline should not be deferred; and (4) behavior standards that apply to the community should not differ from those expected at home.

Intrafamily communications—Many families communicate *too much* to their children—including marital discord, financial problems, anxiety and fearfulness. The return of spontaneity to family relationships is often the first order of therapy in child psychiatry.

Environmental Manipulation

The child psychiatrist is in a unique position to recommend environmental change, an important therapeutic device. Quite often, he suggests that the child benefit from special education or from a return to general education.

When marriages are held together only "for the sake of the children," children are trapped by the disaster around them. Often a trial separation of parents can be beneficial for a child, because it allows the parents to reach an objective viewpoint not possible in the continued turmoil at home.

Child psychiatrists frequently work in close cooperation with social agencies. A child whose major difficulty stems from being born into a disadvantaged family can often be helped by the rehabilitative and social action programs sponsored by these agencies. Environmental manipulation involving foster placement, summer camps, and peer groups may also prove valuable in certain cases.

In several instances severely disturbed children recovered simply by being separated from their severely disturbed parents for some time. Such instances give assurance that the potential for change in children removed from pathologic circumstances will often prevail.

The child is usually benefited by a combination of at least two of the four treatment methods described above; the specific combination of modalities is chosen after careful diagnostic study. Changes in the therapeutic program can be made as clinical judgment dictates.

Implications for the Sociology of Religion of Occult Behavior in the Youth Culture

ANDREW M. GREELEY

There are a number of different but interrelated strains to be observed in the deviant wing of upper-middle-class youth culture:

Woodstock syndrome: passive, unaggressive, withdrawal from the larger society—temporary or permanent—into a subculture shaped by hallucinogenic drugs and rock music.

Political protest phenomenon: ranging from the Weathermen to liberal and moderate groups concerned with active participation in the existing political processes.

The "communitarian" movement: ranging from the communes of Taos or Big Sur to various kinds of encounter and sensitivity groups.

The "neo-sacral" or occult, religious or quasi-religious activities of individuals and groups.

All of these components of upper-class youth culture interact. Astrology is popular with the communitarians, the protesters, and the psychedelics; marihuana permeates all four groups. A young person can move from one emphasis to another with ease; someone "doing his thing" can be engaged now in protest, now drugs, now astrology, and now a Maher Baba commune.

The first three elements are taken seriously by social analysts; the fourth has not been subject to much serious investigation. If psychedelia, political protests, and communes are thought to be important, there is no reason for excluding interest in the occult from social scientific analysis.

One is tempted to suspect that many sociologists would like to exclude it; drugs, protests, even the communes are somehow "legitimate" forms of deviance, but astrology, witchcraft, or diabolism—that is another matter. The characteristic reaction of many social scientists when occultism is brought up is to suggest that it is a passing fad.

One need not delve deeply to find why the neo-sacral is embarrassing: it simply should not have happened. In the classical model according to which most social scientists approach religion, we are in the late phases of the "secularization" process. The race is presumed to have evolved from a mythological society to a scientific society. Man no longer needs to postulate gods to explain storms or the progression of the stars across the heavens. Therefore, it is argued, he no longer needs the sacred or the religious.

Such a model is rarely stated so baldly or explicitly, yet it is, one suspects, implicit, existing just below the surface of most social science consciousness. Obviously, such a model cannot cope with the manifestations of the sacred on the college campus and in the communes where the collegians go when they flee from the campus.

Forms of the Neo-Sacral

Despite its scandalous nature the neo-sacral is still very much with us. There are, it seems to me, three principal forms: *Divination*—attempts to foretell the future or to obtain divine guidance in decision-making through such traditional methods as astrology, the I Ching, or Tarot cards; *Mysticism*—frequently of the Oriental variety and on occasion demanding long hours of silent contemplation and re-

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flection. The Maher Baba groups seem to be particularly popular. *Bizarre cultist groups*—witchcraft covens, diabolic communities, spiritualism groups, and the White Legion.

In the literature on the communitarian movement one sees that it is acquiring religious dimensions. Some communes are explicitly religious while others use religious or quasi-religious concepts to explain their purpose and behavior. The "open land" ideology argues that land "belongs to God"; and the emphasis on "organic food" stresses that such food is "the way God intends man to eat."

It is easy enough to dismiss such comments and the resurgence of the occult as "not serious," or "a put-on" of the scientific, rational society; young people who say that organic food is "God's way" do not really mean "God." But whether they do is a question for research and not a valid a priori assumption. Much of what is going on in the deviant youth culture claims to be religious and looks and sounds as though it were religious. The social scientist must deploy his tools of research in the sociology of religion and determine to what extent he can build models for understanding the current craze for the occult. Whether or not it will last is a research question and to some extent a question that must be left to future analysis. The issue at present is to what extent the perspectives of the sociology of religion enable us to understand the phenomenon.

Pertinence of Religious Sociology

At the present state of the discipline, the sociology of religion sees four principal functions that religion plays in human life: it provides meaning; it is a basis for community; it is an attempt to establish contact with the "sacred"; and it provides or reinforces norms according to which a man may live.

It has been argued that religion is a "culture system" providing a "template" by which man can "interpret" those phenomena which baffle him. When science, common sense, ideology, and art are not sufficient to cope with crises of interpretation, man turns to his "ultimate" cultural system. Religion, in other words, is man's world view.

Other writers have pointed out that human religious rituals are a means of establishing contact with the "really real"; that is, the basic order of things which underpins the universe.

Although relatively little has been written about the relationship of religion and ethics, it is implicit in the notion that religion is a "cultural system" or an "interpretive scheme" that religion also provides ethical meaning for life. The "ethos" and the world view are but different sides of the same coin. The world view tells us the way things really are, and the ethos, how we must live to be in harmony with the way things really are.

Neo-Sacral Research Today

In the present state of research one cannot describe with certainty the functions that the interest in the sacred plays in the lives of the devout and the initiate. But one can observe that the young people who are involved do assert that their sacred, mystical, or occult interests do provide them with meaning, with community, with a contact with the transcendent, and with norms by which to live. Indeed, they are explicit in contending that they have turned—or returned—to the sacred because the scientific, technological society has failed to provide them with faith, community, transcendence, and morality. If what they are engaging in is not a more-or-less authentic form of religious behavior, one wonders what kind of behav-

ior would be acknowledged as authentically religious.

Those members of the political new left who are not yet into the neo-sacral nonetheless seem to share the viewpoint of the neo-sacralists.

The argument of many critics from the new left seems to be that "not by reason alone doth man live;" but if man must have something beyong reason, then he comes close to needing something that would be called "faith," and this is precisely what the colleagues of the new left in the neo-sacral movement would have us believe.

Is the new cult of the occult to survive? Perhaps it will depend upon how deep, pervasive, and permanent the alienation of a substantial segment of the population from what they take to be the scientific and technological society. If a sufficient number do continue to be convinced that the nonrational or the transrational—or even the irrational—are an essential part of human living, then the sacred in one form or another is going to be with us for a long time.

The sociologist of religion should not be surprised; for while he may be inclined to accept a strain toward secularization, he knows his Weber and Durkheim well enough to be skeptical about man's capacity to do without faith or the sacred. While he may be startled by the vigor of the new sacred manifestations, he realizes that Weber would not be surprised, and Durkheim would say, "I told you so."

Or, to put the matter more abstractly, a simple, unidirectional model of religious evolution from the sacred to the secular is not able to cope with the new sacred among upper-middle-class young people. A more sophisticated model based in part on the notion of man as a meaning-seeking animal and the notion of man as a community-creating animal has no difficulty in coping with the new sacred—not, at least, after the first shock on hearing of the existence of a witchcraft coven in the apartment next door.

But while the sociologist of religion will not be completely taken aback by the resurgence of the sacred among the younger generation, he is presented with something of a problem. For if the sociologist of religion is an agnostic, he is caught in the ambiguous position of arguing that society needs religion—or that man needs ultimate meaning—while asserting that he and most of his academic colleagues need neither religion nor meaning. He is more than somewhat dismayed that some of his students do not wish to avail themselves of such exemptions and are on occasion wont to imply that he is less than human himself because he has taken the exemption.

The Public Health Nurse in Community Psychiatry

David W. Adams

The emphasis in North American psychiatry has turned toward maintaining patients within their community, thus resulting in the need for general practitioners, social service workers, and public health nurses to become skilled in the recognition, assessment, and management of patients with emotional disturbances. The public health nurse could become an important member of the psychiatric health care team, for, through visits to the home and school and through well-baby clinics, she has access to situations which range across class lines and bring her into contact with every type of social and emotional problem.

General Problems

The public health nurse is not accepted by many general practitioners, social workers, and psychiatrists as being a member of the treatment team. Professional rivalry and a lack of understanding of the public health nurse's capabilities often serve as a rationale for excluding her from patient care programs.

Most medical officers have failed to recognize the need for intensive public health nurse involvement in coping with the emotional problems of families. Rules which have forbidden them to contact psychiatric facilities directly, call case conferences as necessary, and visit families during evening hours have reduced or prevented involvement of public health nurses in community psychiatric care programs.

The image of the public health nurse as a therapist has not been communicated to the public, and justifiably so. The public health nurse has never been viewed as one to help a patient or family cope with emotional problems, even though she may have been a supportive intervener within the family. This type of intervention may have been beneficial and may have enabled the family to cope with crisis after crisis. However, the public health nurse, because of her lack of therapeutic training and skill, may have been unwittingly reinforcing the pathology which precipitated the recurring crises. The public health nurse could be trained to recognize emotional problems more readily, to carry out goal-oriented, reality-based, short-term therapy and could become recognized by patients and other professionals as a competent helping person.

Some Observations from Recent Experience

A major item during a "Public Health and Mental Health: Community Perspectives" seminar was the exploration of the need for programs that would provide continuing educational experiences. The positive response of the public health nurses toward such experiences marked the beginning of exploration, planning, and implementation of educational programs in six of the seven districts in the Midwestern Region. Personnel from the McMaster [Ontario] Network assisted the public health nurses and community resource personnel in the development of programs to assist public health nurses in coping with mental health problems in their own caseload.

After a 6-month period the programs were assessed; the assessments pinpointed some relevant and pressing problems:

The public health nurse's difficulty in defining her role within the com-

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munity health care system mounts as the number of community care agents increases. The core area of the city and its overwhelming number of problems and would-be helpers tend to lead the nurse toward narrowing the focus of her operations to the point where her role is secure and comfortable but often ineffective and irrelevant; her fears, confusion, and irrelevance can easily go unnoticed.

As a practitioner in community psychiatric programs, the public health nurse tends to assume the role of the community receptacle for cases which no service facility will treat on an ongoing basis. The unmotivated, the multiproblem families, the manipulators, and other so-called untreatable cases can find their way into the public nurse's caseload. The public health nurse becomes known as someone who doesn't demand information to help her cope with the case, and someone who doesn't insist that the service facility provide the time-consuming backup service to help her function effectively.

In her everyday caseload the public health nurse enters problem situations that demand skills she has never been taught. She may not be able to recognize emotional disturbances or certain types of psychiatric problems, let alone help her patients or their families to cope with them.

In some instances she is quite unfamiliar with admission policies and procedures of psychiatric and rehabilitative facilities available.

The McMaster Program in Hamilton-Wentworth

In the Hamilton-Wentworth area, McMaster personnel, particularly staff from the Field Unit of the Department of Psychiatry, assumed the position of group discussion leaders and conducted a series of eight to ten case-oriented sessions for six groups of 10 to 12 public health nurses. Group discussion leaders consisted of one psychiatrist, one resident psychiatrist, two social workers, one psychiatric nurse educator, and one psychiatrically oriented public health nurse. Leaders received general guidelines from the project coodinator and were expected to develop educational programs depending upon the explicit requirements of the public health nurses. There were three main objectives: to provide opportunities for public health nurses to learn how to manage emotional problems more effectively; to assist public health nurses in making more efficient use of community resources; to help the public health nurse cope with her own role problems.

Since each group was composed of nurses serving under one supervisor, each tended to be unique, in respect to not only the geographic area served, but to its mode of practicing. Problems rated as priority tended to vary, and each discussion developed as an independent program. There were, however, some common theoretical inputs relative to all programs:

Improvement of interviewing skills and assessment techniques.

Development of a deeper understanding of family dynamics and the effects of emotional and social disturbances on family life.

Comprehension and utilization of crisis intervention techniques.

Review of the basic stages of child development and the relationship of developmental sequences to social and emotional problems of children and youth.

A Case Example for Teaching Purposes

In my involvement as a discussion leader with the public health nurses serving the rural area of Hamilton-Wentworth, I utilized a case discussion session preceded by theoretical

data related to the presenting problem. A review of a hypothetical case example provides an illustration of the type of problems discussed and how the discussion works toward achieving the objectives of the course.

Johnny is a nervous 6-year-old boy in grade 1. He has been irritable, rebellious, and hyperactive. Three weeks ago, he assaulted two 5-year-old girls and last week brutally attacked a neighbor's cat. His teacher is concerned about his poor performance in school and his unusual behavior. At recess, Johnny avoids boys his own age and spends his time in a corner drawing pictures in the earth. Last week the public health nurse visited Johnny's home. His mother, a 34-year-old housewife, appeared depressed and uninterested in Johnny's problem. She stated that although Johnny is an only child, he has been neglected because his father has been working long hours and she has been too tired to do much more than prepare Johnny's meals. The nurse returned when Johnny's father was also home. His father, a factory worker, was extremely concerned about Johnny and worried about his wife's unhappiness. The parents have agreed to have the public health nurse return and are willing to utilize any help offered.

This example lends itself to: input of theoretical material related to the normal behavior of a child in early latency; review of the importance of the roles of father and mother in creating normal behavior patterns of children; review of factors which have precipitated the mother's emotional problems; review of psychiatric facilities which can be utilized as a treatment resource and backup facility; and design of a plan for management of the case.

Observations of interviews, films on areas such as adolescent behavior, videotapes of family interviews and role-playing of public health nurse interviews also were utilized.

Evaluation of the Hamilton-Wentworth Program

The relationship between the Hamilton-Wentworth public health nurses and staff from the McMaster Network has yielded positive results. An evaluation of the program was completed by 64 of the 70 nurses participating.

Presentation—The case discussion method was useful and desirable.

The focus upon their managing cases rather than immediately referring them to another resource was valuable in aiding them to develop their skills in coping with emotional problems in their own caseload.

The videotapes, films, role-plays, and observed interviews were useful learning tools for studying diagnostic and management techniques.

The use of group discussions introduced sharing of resources readily available to assist the public health nurse in assessing and coping with problem situations.

The nurses suggested that direct assistance in interviewing in the home and supervisory observation of public health nurse office interviews would provide the most desirable learning experiences. Main criticisms of the presentations were that they were too few and did not cover enough areas in depth.

Learning experiences—The public health nurses cited the following areas as those yielding the most favorable learning experiences:

1. Recognizing mental health problems within their caseload.
2. Understanding and coping with children with emotional problems.
3. Comprehending and treating emotional problems within the family.

A need for further case management consultation was indicated in

areas such as mental retardation, geriatrics, psychosomatic disorders, and other areas not covered in group discussions because of their low priority among the public health nurse's concerns.

General comments—Public health nurses stated that discussions, challenges by the group leader, and the undertaking of more responsibility in managing cases and coordinating community services had improved their self-confidence and enabled them to delineate their role in community mental health programs more clearly.

Some Suggestions for Change

There is little doubt that the McMaster program marks only a beginning in alleviating the problems of public health nurses in community psychiatry in the Midwestern Region. A marked impact will be seen only if educational programs and consultative involvements continue on an intensive basis for a number of years.

Concrete learning experiences tied tightly to the everyday experiences that face public health nurses are the key to assisting them in their efforts in community psychiatry. Professional resources must be made available to help them sort out the tangle of service workers which deal with patients, to help them coordinate care programs for patients who must be treated, followed up, or maintained in the community, and to help them participate in these programs. There is little doubt that such education will be useless unless medical officers of health, nursing directors, and nurse supervisors are willing to grant public health nurses the freedom to challenge decisions, to negotiate their roles, and to demand the right to competent back-up assistance. Concepts such as teamwork or role specialization, complete with job allotments based upon the public health nurse's own interests, skills and abilities, warrant immediate consideration.

In effecting the implementation of new educational programs and the freedom to participate in new areas such as community psychiatry, the public health nurse has a key role. Nurses who are willing to challenge other professionals, to confront the health unit administration, and to assume the major responsibility for shaping their own destiny are required. Such behavior is necessary to show the community that the public health nurse can assert herself, is a competent practitioner, and can play a major role in patient services. Patients and professionals in community psychiatry programs need the public health nurse, but she must show them why.

Primary Levels of Underreporting Psychotropic Drug Use

HUGH J. PARRY, MITCHELL B. BALTER, AND IRA H. CISIN

The current period seems to have witnessed a reawakening of interest in response validity in surveys. This paper deals with a special kind of response validity: respondents' reporting of their own legal use of psychotropic or psychotherapeutic drugs, that is, sedatives, stimulants, and tranquilizers.

We are directing a study of the acquisition and use of psychotropic drugs by American adults. Our first step was to devise a questionnaire that would approach the subject in different ways, directly and indirectly; sometimes going from symptom to psychotropic drug; sometimes going from drug to symptom. With this approach, we felt we could improve the validity level. Our second step, perhaps the more important, was to bring in visual aids to stimulate the respondent's memory. We were provided with charts composed of color photographs of the more commonly used sedatives, stimulants, and tranquilizers.

Low levels of validity in psychotropic drug research appear to stem from at least three factors: (*1*) the characteristics of the respondent, such as extreme age, poor memory, low socioeconomic status, a state of sedation; (*2*) the medical or pharmaceutical milieu, e.g., some doctors do not tell what their prescriptions are, and pharmacists do not necessarily label prescriptions; (*3*) those deriving from social pressures, e.g., stimulants are less "legitimate" than sedatives or tranquilizers since they may be used for pleasure or vanity, and tranquilizers may have an aura of the mental institution about them.

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The problem was to get a known group representative of a psychotropic-using population and not the usual sample of institutionalized respondents or odd-lots of patients from scattered sources. At this point, serendipity entered the picture—for other purposes a file had been put together listing all medical prescriptions in a small city over a 5-year period.

The Survey: Location and Design

The study was conducted during 1968–69 in a midwestern city which can be called "Oldenburg." Oldenburg, with a current population under 50,000, is a self-contained city surrounded by farmland. Oldenburgers do their shopping at home—a factor of primary importance in the survey design. The inhabitants are predominantly white. They are older than inhabitants of the State as a whole; more likely to be foreign-born or to have had parents born outside the U.S.; somewhat lower in education and income; less likely to commute to jobs.

The study design called for three experimental groups and three comparison groups of approximately 150–200 cases each, all drawn from the master list as follows:

Experimental groups

1. Sedatives: All persons who, during the first half of 1968, had filled prescriptions for any common prescribed sedatives.

2. Stimulants: Same conditions as for sedatives.

3. Tranquilizers: Same conditions as for sedatives.

The experimental groups are sometimes treated separately and sometimes combined for the purposes of analysis.

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Comparison groups

1. Antibiotic group: All persons who, during the first half of 1968, had filled prescriptions for the 25 common prescribed antibiotics, but who had *not* filled prescriptions for sedatives, stimulants, or tranquilizers.

2. Tranquilizer short-form questionnaire group: All persons who had filled prescriptions for tranquilizers during the first 6 months of 1968.

3. Former users of tranquilizers: Persons who had filled prescriptions for tranquilizers between the beginning of 1966 and end of 1967, but who filled *no* prescriptions for psychotropic drugs since then. This group of former users was administered the long-form questionnaire with color charts. Comparison with current transquilizer users would give a measurement of the effect of time on validity.

In the case of the antibiotic comparison group the long-form questionnaire was employed along with a special color chart of 25 antibiotics. Since the procedures were identical for the psychotropic groups and the antibiotic group, the hypothesis is that differing rates of validity of response will stem from such factors as differing concepts of the "legitimacy" of the medical use of the two classes of drugs, or from differing patterns of prescribing and taking them.

For comparison group 2, no color photo-chart was used, and the questions about psychotropic drug use were short and direct. Here, we postulated that differing rates of response validity would stem from the visual aids and the more thorough approach used on the experimental group.

No interviewers had lived in Oldenburg or had relatives or close friends there. Interviewers worked blind. Questionnaires for the samples were evenly assigned and interview numbers were double-coded, with the second enciphering being random. The presence of the antibiotic group plus a certain number of "user" respondents who denied having used psychotropes provided a sufficient number of nonusers so that we would not run the risk of interviewers becoming suspicious at an almost 100 percent rate of drug use —far above the national rate of about 25 percent current use and about 50 percent ever used.

The computer printout lists were checked against the city directory and the telephone directory before samples were drawn. Only persons identifiable by name and address were interviewed. As a result, completion rate was 90 percent, most of the loss stemming from refusals.

The samples were made up of persons over age 17 who had filled prescriptions locally for certain types of drugs during certain periods of time. They differ from the general population of the city to a greater or lesser degree depending on the drug, and to a lesser extent from each other. The psychotropic drug groups differed from the antibiotic control group in only one respect: they were predominantly female. Female predominance is notable in the stimulant group, and here at least one factor is the greater use by women seeking to control weight. Among the three psychotropic drug samples, the sedative group was considerably older, poorer, and less educated.

Interviewers reported in nine out of ten cases respondents were "very cooperative." They also expressed a high level of confidence in the validity of the responses they were getting—a confidence which was not always justified.

First-Level Validity of Response

This paper is limited to "first-level validity." Does a respondent who is

known to have filled one or more prescriptions for a certain type of psychotrope affirm or deny that fact? This measure is simple but basic to our long-range study: a respondent who denies known past behavior will never get the chance to respond to the followup questions.

In measuring this first-level validity or response, we allowed for three categories: *valid*—when a respondent from a specific sample (e.g., stimulants) states that he has taken a stimulant; *partly valid* (or confused)—when a respondent from a specific sample (e.g., stimulants) denies that he has ever taken a stimulant but says that he has taken one or another of the other classes of psychotropic drugs; *invalid*—when a respondent from a specific sample denies that he has taken any psychotrope. (In the case of the antibiotic control, only two categories of valid-invalid could be used.)

Differing rates of response validity between three classes of psychotropic drugs—Users of three classes of psychotropic drugs operated at different levels of response validity, with the tranquilizer group significantly more likely to give valid responses. This can, in part, be explained by the smaller proportions of very old people, the poor and poorly educated, and those with language difficulties found among the tranquilizer group. But these variations do not explain why validity levels are higher for the tranquilizer group than for the stimulant group, since the latter is younger, better educated, and richer. The answer lies in the high proportion of "partly valid" responses given by the stimulant group who denied having used stimulants but said they had used sedatives or tranquilizers or both. It appears to be more legitimate to turn off than to turn on. Relatively few persons use the "down" drugs for pleasure, experimentation, or "vanity" (weight loss). There is also a greater belief in the dangers of stimulants. Such ambivalence and disapproval may help to swell the proportions of evasive, as distinct from confused, responses for this class of drug.

Differing validity levels between psychotropic and antibiotic drugs—Antibiotic drugs do not have attached to them the social stigma, ambivalent attitudes, and lack of legitimacy with which many Americans label psychotropic drugs. Our expectations were that validity levels for antibiotics would be higher than for psychotropes. We found just the reverse. While there may be social pressures limiting response in the case of psychotropic drugs, these appear to be outweighed by situational forces militating against valid response for antibiotics. Antibiotics are normally used in acute situations over a short period of time; renewal of prescription is infrequent; the infection is not likely to recur. All these factors may act against recall. Psychotropes are more often associated with chronicity, recurring episodes, continued refilling of prescriptions—all factors aiding memory.

The lower level of validity of the antibiotics samples does not appear to stem from the differences in education and sex.

The use of intensive questioning plus visual aids—A third question covers contrasting research instruments: a long, probing interview versus a single standard "have you" question; and the use of color charts versus no visual aids. Our hypothesis was that validity of response could be improved markedly by the more elaborate approach. The belief was justified.

Effects of time on validity of response—What of the former users of

psychotropic drugs who filled prescriptions some time before the survey and who have not filled or refilled prescriptions since that date?

The results suggest that the time factor is of marked importance. Among current takers of tranquilizers (when the long-form questionnaire and the color chart are used) validity is better than 80 percent. Among former users, with the same interview techniques, validity drops to less than two-thirds.

Factors Connected with Invalid Responses

Four factors appear to be associated with invalid responses for psychotropic drugs. These, in descending order of importance, are: education (respondents with no more than eighth-grade education); interviewer rating of respondent cooperation (those rated as anything less than "very" cooperative); sex (males); and language difficulty. When more than one of the four criteria were combined in a single respondent, the chance of invalid responses rises still higher. With respect to the higher level of invalidity of male respondents, it should be noted that psychotropic drugs are used by at least twice as many women as men. Additionally, men have been more likely to hold derogatory stereotypes of the psychotropic drugs and of their users. About 29 percent of the males gave invalid responses compared to 18 percent of the females.

The data show that the questionnaire item in which interviewers are asked to assay the validity of respondents' answers works poorly, whereas their assessment of cooperativeness is a better gauge of validity. They also suggest that composite ratings of interviewer ability are not connected with validity of respondent answers, or that such ratings fall somewhat short of accuracy.

When the same analysis was repeated for the antibiotic group, the only factor connected with invalidity and common to both groups was low education.

How well can these Oldenburg validity levels be applied to national psychotropic drug research? A provisional answer can be given by taking two major concomitants of invalidity —sex and low education—and then comparing the national psychotrope users with the Oldenburg samples. Nationally, there are more males—a factor reducing validity; and also a higher proportion of the better-educated—a factor raising validity. When the Oldenburg validity levels are weighted in terms of these factors, the two cancel out. However, the fact that a few other characteristics are found more often in Oldenburg than nationally—language difficulty, for example —would suggest that validity levels in a national study of psychotropic drug use might be a few percentage points better than in the Oldenburg study.

Family Care as a Useful Alternative to the Long-Term Hospital Confinement of Geropsychiatric Patients

EMMERICH N. RISDORFER, GEORGE PRIMANIS, AND LOUIS DOZORETZ

The prevailing social philosophy governing the treatment of the psychiatric patient focuses on the importance of the community as a reconstructive force. In a program which recognizes this trend, Binghamton State Hospital has been developing a comprehensive utilization of supervised family-care homes for a rehabilitative rather than custodial environment.

The idea of community care for mental patients has been in existence in Europe for hundreds of years and has been adopted in the United States ever since Dorothea Dix introduced these ideas in 1857 after a trip to Scotland. As a result, the Scottish plan for the return of patients from mental institutions to private homes was initiated. In 1869, the *American Journal of Insanity* presented the Scottish system as a plan for "boarding out" mental hospital patients, emphasizing the following aspects:

(*a*) Placing the mental patient in a sane society.

(*b*) Training the patient for some industrial pursuit.

(*c*) Allowing the patient more personal liberty and a nearer approximation to the ordinary mode of social life.

The Binghamton State Hospital has used these objectives in determining the suitability of the patient for family care. In 1935, the Family Care Program started with the placement of 14 patients. It was not planned specifically for geriatric patients. Steady growth in the number of elderly patients in Binghamton State Hospital and increasing awareness of the needs of the elderly led the hospital staff to explore the advisability of placing geriatric patients in community facilities. The use of existing family-care homes as supervised boarding homes seemed expedient. In these homes, the patients receive not only custodial care, but also can participate in household activities, and can find pleasure around the grounds and in the usual social activities of the community.

Boarding out of geriatric patients in family-care homes is prescribed for persons whose contacts with friends and family have eroded or disappeared, and who have no place to go after release from the hospital. The criteria for placement of geropsychiatric patients in family care homes are similar to those for placing them within their own families. To be eligible, geriatric patients must be in at least fair physical condition. They must be ambulatory, continent, and able to take care of their personal hygiene. The family-care home is used for patients who are functioning too well to be sent to a nursing home but are not capable of complete independence.

This report concerns 113 geriatric patients residing in family-care homes; through October 1969 there were 36 males and 77 females ranging in age from 65 to 85 or older. The percentage of females was more than double that of the males—68.1 versus 31.9 percent. Geriatric males are more easily accepted in the homes of distant relatives or friends, but geriatric fe-

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males are more demanding and create more difficulty in the management of their daily life.

Most of the male patients were placed in family care after 1 or 2 years in the hospital. Most of the females were not placed until 6 to 10 years after admission. Nineteen patients (16.8 percent) were placed after 21 or more years of hospital care.

In October 1969, most of the patients (26 males and 49 females, for a total of 75) had been under family care for 1 to 2 years. This was the result of organizing a new Geriatric Intensive Treatment Unit in the Binghamton State Hospital. In 17 months 83 patients were placed in family-care homes. Of these, only seven (8.6 percent) were returned to the hospital unit.

The leading diagnoses for the males were psychosis due to cerebral arteriosclerosis (38.9 percent) and schizophrenia (25 percent). The leading diagnoses for the females were in reverse —schizophrenia (46.6 percent) and psychosis due to cerebral arteriosclerosis (19.4 percent). Psychosis due to alcoholism was a prominent diagnosis in males (16.6 percent versus 1.2 percent in females).

The Binghamton State Hospital Family Care Program has about 60 family-care homes for about 390 patients. Since the partial utilization of Binghamton State Hospital, these homes have been assigned to the teams of Broome County Unit. They are administratively supervised by the social workers on the teams, and other team workers participate.

In the selection of family-care homes, we try to provide a homelike atmosphere for our patients which will meet their physical and emotional needs and enable them to rebuild their strengths and abilities. There should be adequate space in these homes for recreational activities and for comfortable sleeping quarters. Family caretakers are selected for their capacity for mature supervision and their ability to understand and empathize with emotionally disabled patients. An attempt is made to instruct caretakers in helping the patient in his progress toward resocialization.

Such a home provides the patient with a bed, closet, dresser, food, and general hygienic items. The patient is expected to maintain good personal hygiene; however, he often needs supervision and encouragement by the family caretaker.

In promoting independent functioning and self-sufficiency, a fine balance must be obtained between just allowing a person to live in a home and giving him supervision and encouragement. With this in mind, matters like transportation and recreation are handled in the family-care homes. Family caretakers should be aware of community transportation facilities and should help their patients to use them. However, at times when the available facilities are inadequate, the hospital has to arrange transportation.

Family caretakers encourage their patients to use recreational facilities in the community. For patients who cannot venture into the community, television and other home entertainment will fill the purpose. Each patient is encouraged to involve himself in activities of some kind and once a year the hospital arranges a picnic for all the home-placement patients. In many homes, patients will help with the household chores; in the rural homes, they will do some garden work. In 1968, approximately 50 percent of the homes had patients who were working in competitive industry or were attending vocational schools.

Medical and psychiatric supervision involves community facilities as much

as possible. Once a year each patient receives a routine physical examination. For any physical ailments, the services of medical practitioners in the community are used for all patients who are covered by insurance, welfare support, or their own finances. Psychiatric medication is supervised, and drugs are prescribed by the doctor on the team responsible for the family-care home. Patients are visted by team members at least once a month. For acute physical problems or emergencies, physicians in the community are called. If they cannot be reached, a backup service is always available in the hospital. If an illness requires hospitalization, the team physician decides whether the patient should be admitted to a general hospital or to a State hospital.

In our experience, a mixed-age population has no disadvantages for either elderly psychiatric patients or younger ones. Patients who are discharged from the hospital intensive treatment program find themselves in a more lifelike situation in the age-and-sex mixed homes. Thus, these mixed homes provide a better transition for the re-entry of the patients into the community. The relationship of old and young, male and female, is greatly influenced by the role the caretaker assumes. Many caretakers act as effective moderators and help the development of a good relationship.

The family-care system has proved to be the best means for helping the patient in his transition from hospital confinement to life in the community. If a patient cannot adjust to the home, he is interviewed by a mental-health worker or a psychiatrist on the team. On the basis of findings, the patient may be: transferred to another family-care home, given a change of medication, placed under regular outpatient psychiatric supervision, or returned to the hospital.

The financial structure of our family-care system is as follows: The hospital establishes contact with the family caretaker, who is paid $150 or $155 per month by the Department of Mental Hygiene. The $155 rate is for the patient who has no funds of his own and is allotted $5 per month for personal spending money. If the patient has money of his own, he can be allotted more than $5 to cover luxury expenses. Patients receive medications, therapeutic devices, and clothing from the hospital. If they have no medical insurance or other coverage, they receive all medical care from the hospital. If they have medical insurance, Medicare, or welfare support, they obtain care for physical illnesses in the community.

An efficient family-care service has several advantages. Patients are returned to community living, although in a supervised situation, and are encouraged to develop an independent, self-sufficient attitude. It is of great importance that geriatric patients be free from the stress and responsibility of managing their daily problems, while maintaining some relationship with other patients and, when possible, venturing out into the community.

The advantages of the hospital are: family-care placement permits better utilization of the hospital for patients who require residential treatment, such placement is more economical for the hospital, and it is more conducive to "normal living" of the elderly person within the community.

Mental Health News Digests

Nationwide Family Advocacy Service Program

The Family Service Association of America is the national, accrediting, standard-setting federation for more than 340 nonprofit, voluntary, family-serving agencies throughout North America. The FSAA program consists of a battery of services that strengthen family life and alleviate family stress by professional counseling, specialized help, and advocacy to improve social conditions that affect family life.

The Nationwide Family Advocacy Service Program is a major thrust to improve the quality of life in America to: pioneer in overcoming community inadequacies that cause family problems; expose the underlying problems that result from community inadequacies; and, provide more effective services for family problems and to prevent erosion of the community structure. This emergency program will be established as an integral part of family services throughout North America, especially in geographical areas populated by concentration of minority group families.

Institutional change is the broad framework of the Advocacy and related programs. This change requires the incorporation of minority group perspectives at every level of the family service system. Long-range planning, education, and analysis are essential preliminaries to arriving at positions, developing policies, and promoting their wide understanding and acceptance. The range of need for input from the Family Advocacy framework covers welfare, housing, health services, education, and employment.

Resulting from FSAA's strong commitment in the Family Advocacy program, genuine progress has been made already. As an example of Family Advocacy, a Family Service agency was recently able to help some distressed families when they were denied emergency public aid. The agency arranged for the badly needed funds and services and called to the attention of the Department of Public Welfare the need for a revision of the existing welfare laws. Various agencies are also working with city officials to bring about improvements in housing and education systems in depressed areas.

Family Service agencies are in the most strategic position to know what social conditions are hurting family life. Widespread efforts to change systems that are working badly for substantial numbers of families, as well as to help them cope individually with their problems, have made the Nationwide Family Advocacy Service Program timely and possible. For information concerning this program write to: The Family Service Association of America, 44 East 23rd Street, New York, N.Y. 10010.

Interns, Residents and a High School Drug Program

Twenty-five interns and residents from Strong Memorial Hospital in Rochester, New York, anxious to do something about the drug abuse problem, are combining academic medicine with involvement in community affairs. In doing so, these physicians have become aware of an alarming number of cases of students in suburban high schools deeply involved in drugs, and the sources as well as the recipients of drug misinformation. To help these students, an education service on drugs was instituted by the house staff at the hospital.

An extensive bibliography was compiled with the help of recognized authorities on drug abuse and formed the basis of the service. House officers from the departments of medicine, pediatrics, pathology, and anesthesiology held seminars on drug abuse and exchanged references. Eleven area high schools welcomed the proposed project. Each house officer was assigned to a specific school and, having arranged a mutually convenient schedule, spent several half day sessions discussing drugs with four or five classes of 20 to 30 students each. The sessions began with 15 to 20 minutes of didactic lecturing, the rest of the hour being spent in discussion with the students. This approach generated questions more than sessions with less structure. The small size of the groups encouraged better dialogue than would have assembly type meetings.

In answering questions, these interns and residents are reaching students undecided about drugs and giving them a better basis on which to decide whether or not to "turn-on."

(Adapted from *Resident and Staff Physician,* March 1971.)

Stimulant Drugs for School Children

The U.S. Office of Child Development has released the report of a panel of experts who met to develop guidelines for proper administration of amphetamine drugs to school children with behavioral disturbance problems. The report indicates that use of such medication in treating hyperkinetic behavioral disturbance improves the child's attention, learning, and social abilities, and there is no evidence that proper use of amphetamines in treating this age group leads to addiction in later life.

The report also stresses the importance of careful diagnosis taking into account the child's environment and family relationships as well as physical and psychological data. Other guidelines for use of the drugs include statements that school personnel must never attempt to persuade parents to accept any particular treatment, although it is proper for them to draw parents' attention to a child's behavior problems and to cooperate with a physician in a treatment regimen. It is also stressed that manufacturers of stimulant medication should promote their products solely through appropriate medical channels, never through school personnel. Furthermore, no child should be given the responsibility for taking his own medication. The panel of experts also emphasized the need for further research into causes, prevention, and treatment of all behavior disorders in children. Copies of the report are available from the Office of Child Development, P.O. Box 1182, Washington, D.C. 20013; mark requests "Drug Panel Report."

Marriage Counseling in College

The number of married students on college campuses has steadily increased since World War II, necessitating the establishment of several unique services directed toward married students. At Colorado State University, personnel from the counseling center have designed an innovative program directed toward meeting needs of married students. In 1968 the idea was launched with a survey to establish the degree of interest in such programing; an initial series of evening workshop seminars attracted eight couples. Interest in the program has grown to such an extent that now 100 couples are participating in the workshop series. The workshop seminars are focused on normal couples, and they are open to students who are married, engaged, going steady, or liv-

ing together. In order to teach normal couples how to grow within the marriage and how to make marriage a richer experience, the program stresses the teaching of basic communication skills that couples use throughout all stages of married life. The program is deliberately aimed toward preventing marital problems and promoting health rather than toward concentration on pathology or marital problems.

(Adapted from *Campus Community Mental Health Services,* Western Interstate Commission for Higher Education, March 1971.)

Tuscaloosa Community Program

The Veterans Administration Hospital, Tuscaloosa, Alabama, has been designated to develop the nation's first VA community mental health program. The goal is to develop a model program to reach the emotionally disturbed veteran in his community, to provide mental health services for the veteran and his family in their home surroundings, and to discourage long stays in psychiatric hospitals whenever possible.

The VA is investing $125,000 in the first 6 months of the program, a projected $250,000 for the next fiscal year, and probably $500,000 for each of 5 more years once the program is fully operational.

Two teams of mental health workers are now making trips into 21 northern Alabama counties to implement the program. Team members include nursing assistants, social workers, psychiatrists, psychologists, mental health associates, registered nurses, statisticians, and secretaries.

Drug Information Network

In August 1970, a Drug Information Network became operational and began to serve physicians in the regions of South Dakota and Nebraska. The Drug Information Network's main center is located in Lincoln, Nebraska. It employs full-time drug information pharmacists, and a clinical pharmacological consultant aids in providing services from the center. Five sub-centers, located in pharmacy departments at hospitals throughout South Dakota and Nebraska, are utilized in order to keep the network in operation 24 hours a day, 7 days a week. Physicians may telephone their inquiries to the subcenters at any time; all phone calls are tape-recorded, and tapes are transcribed daily. The physician's inquiry is answered by telephone, and written documentation of the answer is sent to the requester within 24 hours. Physicians in the South Dakota-Nebraska region may call the Drug Information Network by dialing (800) 228–4011 preceded by the local dial access number.

(Adapted from *South Dakota Journal of Medicine,* March 1971.)

National Technical Information Service

In order to simplify and increase public access to Federal publications and data files the National Technical Information Service (NTIS) was established within the U.S. Department of Commerce in September 1970. The Clearinghouse for Scientific and Technical Information, formerly in the National Bureau of Standards, was transferred into the NTIS and its functions were merged with the broader missions of NTIS.

NTIS has a dual responsibility: (1) to coordinate Commerce business and technical information activities and (2) to serve as the primary center within the Federal Government for collecting, announcing, and disseminating technical reports and data. NTIS processes over 50,000 reports

annually through its announcement services, and it distributes most of the reports in microform or paper copy. In addition to the announcement and distribution services NTIS also performs a selected reference service. Key announcement services of NTIS are: *Government Reports Announcements* (formerly *U.S. Government Research and Development Reports*), *Government Reports Index* (formerly *U.S. Government Research and Development Reports Index*), *Government Reports Topical Announcements, and Fast Announcement Service.* Further information about all NTIS services may be obtained from the National Technical Information Service, U.S. Department of Commerce, Springfield, Va. 22151.

The American Psychology-Law Society

The American Psychology-Law Society was founded in September of 1968. The membership, approximately 300, is currently about two-thirds comprised of psychologists. The purposes of the organization are: to promote exchanges between the disciplines of psychology and law; to promote research relevant to legal and psychological problems using the knowledge and methods from both fields; to promote education of lawyers and psychologists in both of these disciplines; to promote legislation and social policies consistent with current states of psychological knowledge; to promote the effective use of psychologists in the processes and setting of the law; and to promote any and all other activities which may lead to effective interrelationships between psychology and law.

For further information concerning the American Psychology-Law Society, write to Robert J. Howell, Ph.D., 1234 SFLC, Brigham Young University, Provo, Utah 84601.

Special Journal Issue on Group Work

A journal issue devoted entirely to group work has been published by the American Personnel and Guidance Association. In addition to several articles on practice, theory, and training in group work, the issue includes a list of sources for short-term group training experiences, a description of current periodical literature of group work, a bibliography of literature on groups, a list of audio-visual materials for group workers, and a group of selected reviews of books on several aspects of group work. This special issue is Volume 49, No. 8 (April, 1971) of the *Personnel and Guidance Journal.* Single copies of the issue are available for $2.00 from the American Personnel and Guidance Association, 1607 New Hampshire Avenue, N.W., Washington, D.C. 20009.

New Publications

The University of Pittsburgh Press will be publishing a new book, *Dynamics of Institutional Change,* that will analyze institutional leadership and the dynamics of organizational change. The authors are Milton Greenblatt, M.D., Myron R. Sharaf, Ph.D., and Evelyn M. Stone. Among the issues discussed are the significance of administrative functions, the forces relating to effective institutional management, the pacing of change, the strategy and tactics of decentralizing a large bureaucratic organization, and various other topics.

The second part of the report concerning *Careers After Fifty* and the *Elderly and Minority Groups* has recently been published in the *Gerontologist,* Volume 2, No. 1, Spring 1971. Correspondence concerning the *Research Proposals and Applied Social Gerontology: Second Report, 1971,* should be addressed to Professor R. J.

Havighurst, Judd Hall, University of Chicago, Chicago, Ill. 60637.

Corrections: A Bibliography is now available from the Department of Justice, Bureau of Prisons Library, Washington, D.C. 20537. The bibliography includes listings of various publications and periodicals covering the history of penology, the prison social system, institutional treatment and rehabilitation in adult correctional institutions, community corrections, and various other topics. Also listed are publications available from the U.S. Bureau of Prisons, the American Correctional Association, and the Joint Commission on Correctional Manpower and Training.

Halfway House Manager's Training Program

The Comprehensive Halfway House Manager's Training Program is underway in six Florida cities. Its goal is to develop future managers for some of Florida's halfway houses. The training program, administered by the Florida Association of Halfway Houses, Inc., has been made possible by a grant approved by the Florida Inter-Agency Law Enforcement Planning Council, Task Force on Narcotics, Dangerous Drugs and Alcohol and Abuse.

The program is divided into four primary phases over a 6-month period. Stress is placed on the concept of on-the-job training. Three months are being spent by the trainees in their Primary Training Center working directly under the manager of selected halfway houses. The program has as its goal the training of persons to serve as managers or superintendents of halfway houses for parolees and dischargees from State penal institutions, halfway houses for State mental institution dischargees, or any other transitional residence or domiciliary resource serving persons who need a home away from a bad environment or a home during a period of recovery and rehabilitation. (Condensed from *Insight,* a publication of the Florida Bureau of Alcoholic Rehabilitation, March 1971.)

Manhattan Bowery Project

Effective care of the homeless, sick alcoholic has been accomplished by cooperation of community, medical, governmental, and legal resources at the Manhattan Bowery Project. This 48-bed unit was set up more than 2 years ago on an abandoned floor of the Social Services Building in the Bowery. Since then, there have been 6,000 admissions to the Project. The program used recovered alcoholics to approach inebriated men on the street and persuade them to enter the unit for treatment. Seventy percent of the men solicited agreed to enroll.

Each patient is given a thorough examination, including psychiatric screening. Five caseworkers are present to evaluate patients and to recommend referral to one of 20 aftercare programs. Sixty-five percent of the patients take such referrals. The project has its own followup clinic; disulfiram is mandatory, and psychiatric therapy is available. A general clinic also has been set up in cooperation with St. Vincent's Hospital and Medical Center of New York to give ambulatory medical and emergency care. (Adapted from an article by Robert Morgan, M.D., *The Bulletin,* N.Y. State District Branches, American Psychiatric Association.)